

EXHIBIT 1



AFL-CIO

For Immediate Release

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AFL-CIO Calls on Maryland to Deny Johns Hopkins Bayview Expansion Project in Scorching Letter

Nurses Say Letter Shares Concerns Raised by RNs

[Washington, DC, February 19, 2019] - Citing failure to meet charity care obligation for the health needs of low-income area residents that includes suing thousands of low-income patients for medical bills, serious patient care “deficiencies,” and an “unwarranted” major rate hike, the AFL-CIO is calling on Maryland officials to reject the application of Johns Hopkins Bayview Medical Center (JHBMC) for a major redevelopment project.

In a letter to the Maryland Health Care Commission, which must approve a Certificate of Need for the project under state law, AFL-CIO counsels Craig Becker and Yona Rozen say the authorization “should be denied” or at least delayed until the substantial problems it cites are “fully addressed and remedied.” (*letter available upon request*)

National Nurses United, an AFL-CIO affiliate which has been meeting with Johns Hopkins RNs who want to form a union for a collective voice, said it shared the multiple concerns raised by the letter.

“We are appalled at the practice of suing patients to pay for inflated medical bills, and nurses have continued to raise their alarm at serious problems in patient care delivery also cited in the letter,” said NNU Co-President Zenei Cortez, RN.

At the heart of the AFL-CIO complaint is Johns-Hopkins “aggressive” pressure on former patients, including filing thousands of lawsuits, to collect medical debts. Many of those targeted “come from impoverished neighborhoods with large African-American populations as well as others “who live in areas with high poverty rates.”

Here are some of the key issues raised in the letter:

- From 2009 through 2008 Johns Hopkins Bayview filed 2,373 lawsuits, including 604 wage and asset garnishments, to recover debt from patients, many of whom have been forced into bankruptcy. Some were hounded despite owing as little as \$250.
- Lengthy emergency department wait times, likely due to overcrowding reflecting the failure of the hospital to live up “to its core function of providing timely and effective emergency care.

- JHBMC's practices reflect a "pattern of behavior (that) is systematic within the Johns Hopkins Health System" at all its facilities. Overall, the system has filed over 18,000 medical debt lawsuits since 2009.

In this letter, the AFL-CIO general counsels conclude, the significant rate increase the hospital is seeking to help fund the proposed project is "unnecessary and unjustified" that would balloon the hospital's profits by "an astounding 510 percent within the next six years, and create an "unwarranted adverse impact upon the public." JHBMC has requested rate hikes beyond what other hospitals in Maryland have received.

AFL-CIO affiliated unions represent working people in Maryland, the District of Columbia, and Virginia and negotiates with employers for health benefits for employees who are in the service area of the Bayview hospital.

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EXHIBIT 2

117 F.3d 1413

Unpublished Disposition

NOTICE: THIS IS AN UNPUBLISHED OPINION.

(The Court's decision is referenced in a "Table of Decisions Without Reported Opinions" appearing in the Federal Reporter. See CTA4 Rule 32.1.

United States Court of Appeals, Fourth Circuit.

John W. GLUTH, Plaintiff–Appellee,

v.

WAL–MART STORES, INCORPORATED; Wal–
Mart Stores Incorporated Associates Health and
Welfare No. 96–1307 Trust, Defendants–Appellants,
and

WAL–MART GROUP HEALTH PLAN, Appellant.

No. 96–1307.

|
Argued May 5, 1997

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Decided July 3, 1997

Appeal from the United States District Court for the
District of South Carolina, at Rock Hill. Matthew J.
Perry, Jr., Senior District Judge. (CA–93–2682)

Attorneys and Law Firms

Ashley Bryan Abel, ABEL & HENDRIX, P.A.,
Spartanburg, South Carolina, for Appellants.

Stonewall Jackson Kimball, III, KIMBALL, DOVE
& SIMPSON, P.A., Rock Hill, South Carolina, for
Appellee.

Before MURNAGHAN and HAMILTON, Circuit
Judges, and LEGG, United States District Judge for the
District of Maryland, sitting by designation.

OPINION

PER CURIAM.

*1 At age fifty-seven, John Gluth (Gluth) underwent emergency surgery on December 30, 1992, to remove a significant portion of his prostate gland in order to relieve urine retention in the urinary tract caused by benign prostatic hypertrophy (BPH).¹ Gluth subsequently filed

a claim for payment of medical expenses related to his surgery under the health care benefits plan sponsored by his employer, WalMart Stores, Inc. (Wal–Mart). The parties agree that such plan, entitled the Wal–Mart Associates' Group Health Plan (the Plan), is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 to 1461. The Plan's administrator is an administrative committee (the Administrative Committee), which under the terms of the Plan had discretion to make benefit decisions and to interpret the terms of the Plan. The Administrative Committee denied Gluth's claim under the provision of the Plan that excluded coverage of medical expenses for any illness, injury or symptom (including secondary conditions and complications) that was medically documented as existing during the twelve months preceding the participant's effective date of coverage.

Contending that the Administrative Committee abused its discretion by denying his claim, Gluth filed this action against Wal–Mart seeking review of that decision. *See* 29 U.S.C. § 1132(a)(1)(B). After a bench trial, the district court concluded that the Administrative Committee abused its discretion in denying Gluth's claim and entered judgment in his favor for payment of the medical expenses related to his surgery. The district court also awarded Gluth attorney's fees and costs. *See* 29 U.S.C. § 1132(g)(1).

After the district court entered judgment, Gluth moved to add the Wal–Mart Group Health and Welfare Trust (the Trust)² as a defendant. The district court granted the motion. Wal–Mart and the Trust filed a timely appeal. For reasons that follow, we vacate the district court's judgment in favor of Gluth, the district court's award of attorney's fees and costs in favor of Gluth, and the order adding the trust as a defendant, and remand with instructions.

I.

On February 18, 1992, Dr. Robert Lindemann (Dr. Lindemann), a specialist in internal medicine and Gluth's personal physician, conducted a routine physical examination of Gluth. Although Gluth did not expressly relate any symptoms of urinary tract obstruction or urine retention or any symptoms indicative of any prostate gland illness during the examination, a digital rectal examination performed by Dr. Lindemann indicated a

slight enlargement of Gluth's prostate gland. Specifically, the digital rectal examination gave a reading of BPH 1+, with the 1+ indicating the slight enlargement. A prostate gland specific antigen (PSA) test, which is a test used to diagnose prostate cancer in its earliest stages, showed that Gluth had an elevated PSA level of 7.1. An elevated PSA level may be caused by an enlarged prostate gland. Concerned by the results of the PSA test, Dr. Lindemann referred Gluth to a urologist, Dr. W.D. Livingston (Dr. Livingston), for evaluation, which evaluation did not take place until October 1, 1992. Gluth began working for Wal-Mart nearly two months after Dr. Lindemann examined him.³ Gluth subsequently Mart. obtained health care coverage under the Plan, effective July 12, 1992. The Plan, by its terms, excluded coverage of medical expenses for any illness that existed within the twelve months preceding a participant's effective date of coverage. Specifically, the Plan provided that:

*2 Any charge with respect to any PARTICIPANT for any ILLNESS, INJURY OR SYMPTOM (including secondary conditions and complications) which was medically documented as existing, or for which medical treatment, medical service, or other medical expense was incurred within 12 months preceding the EFFECTIVE DATE of these benefits as to that PARTICIPANT, shall be considered PREEXISTING and shall not be eligible for benefits under this Plan, until the PARTICIPANT has been continuously covered by the Plan 12 CONSECUTIVE months. (J.A. 32).

Dr. Lindemann subsequently filed a medical expense form with the Plan on behalf of Gluth for payment of medical expenses related to his February 18, 1992 examination of Gluth. In making this filing, Dr. Lindemann coded Gluth's claim as "600" under the International Classification of Diseases (ICD). Under the ICD, code 600 includes, among other diseases, benign prostate gland enlargement.

On September 23, 1992, Dr. Christian Magura (Dr. Magura), a urologist, examined Gluth at a prostate cancer screening clinic. Dr. Magura's digital rectal examination of Gluth showed a 2+ increase in his BPH reading. Furthermore, Gluth related to Dr. Magura that within the preceding six months he had experienced a strong need to urinate with little or no urine coming out, a symptom of BPH. Part of that time period preceded Gluth's effective date of coverage. As did Dr. Lindemann in February of

1992, Dr. Magura also referred Gluth to Dr. Livingston, a urologist, for further examination. Dr. Livingston's notes from his examination of Gluth on October 1, 1992, indicate that Gluth related symptoms of BPH, but did not specify how long he had been experiencing such symptoms.

By December 26, 1992, Gluth's prostate gland had enlarged to such an extent that it caused him acute urinary retention, necessitating a trip to the emergency room of a nearby hospital. Four days later, Dr. Magura surgically removed a large portion of Gluth's prostate gland to alleviate the urinary retention. Dr. Magura's pre and post operative reports show that he gave Gluth a pre and post operative diagnosis of BPH and urinary retention.

The Plan initially denied Gluth's claim for medical expenses related to his surgery on the basis that they were for an illness, BPH, that was medically documented as existing within the twelve months preceding Gluth's effective date of coverage. Gluth appealed to the Administrative Committee.⁴ As part of its review, the Administrative Committee requested an expert medical opinion regarding the merits of Gluth's claim from Dr. James Arkins (Dr. Arkins), a member of the Plan's medical advisory council.⁵

Dr. Arkins practices family medicine and has nineteen years experience treating mostly persons over fifty years of age. He reviewed Gluth's complete claim file. The file included most of Gluth's medical records and benefit claim forms, including Dr. Lindemann's report of his February 18, 1992 examination of Gluth and Dr. Magura's pre and post operative reports.⁶ He also reviewed the language of the Plan that excluded preexisting illnesses. Based on: (1) his interpretation of Dr. Lindemann's February 18, 1992 report as diagnosing Gluth with BPH;⁷ (2) Dr. Lindemann's referral of Gluth to a urologist due to an elevated PSA, where an elevated PSA can be the result of prostate gland enlargement; (3) a review of the other medical records (including pre and post operative diagnosis by Dr. Magura of BPH and urinary retention); (4) the medical relationship between BPH and urinary retention; and (5) his medical training in general and experience in treating men over fifty years of age; Dr. Arkins reported to the Administrative Committee that the medical expenses related to Gluth's surgery were for an illness, BPH, that had been medically documented

as existing during the twelve months preceding Gluth's effective date of coverage. As a result of its own review of Gluth's claim file and its consideration of Dr. Arkins' opinion, the Administrative Committee affirmed the initial denial of Gluth's claim. In doing so, the Administrative Committee interpreted the term "illness," as used in the Plan, to include BPH.

*3 At trial, the district court considered the evidence that was before the Administrative Committee when it affirmed the initial denial of Gluth's claim for benefits. The district court also considered evidence that was not before the Administrative Committee. For example, the district court heard and considered the testimony of Dr. Lindemann that he did not intend his recording of a BPH 1+ reading from his digital rectal examination of Gluth to indicate that Gluth suffered from an illness. The district court also heard and considered testimony by Dr. Magura on what the district court considered the ultimate issue in the case—whether Gluth suffered from any illness, injury or symptom (including secondary conditions and complications) medically documented as existing or for which medical treatment, medical service or other medical expense was incurred within the twelve months preceding Gluth's effective date of coverage. According to Dr. Magura's trial testimony, Gluth did not so suffer. Wal-Mart objected at trial to the district court's admission of this testimony.

After consideration of all of the evidence, the district court concluded that the Administrative Committee had abused its discretion in denying Gluth's claim for medical expenses related to his December 30, 1992 surgery. According to the district court, the abuse of discretion stemmed from denying benefits on a record that lacked substantial evidence that Gluth had suffered from any illness, injury or symptom (including secondary conditions and complications), which was medically documented as existing, or for which he received medical treatment, medical service, or incurred other medical expense within the twelve months preceding his effective date of coverage. Instead, the district court stated, "there were the opinions of two doctors Dr. Lindemann, the examining doctor on February 18, 1992 and Dr. Magura, a urologist, who both testified that Mr. Gluth's BPH and PSA level were not pre-existing conditions to the acute urinary retention." (J.A. 44) (emphasis added). The district court concluded that it was unreasonable for the Administrative Committee to rely on Dr. Arkins'

interpretation of Gluth's medical records "when it is evident that Dr. Arkins and Dr. Lindemann use the term BPH differently and according to Dr. Lindemann his diagnosis of Mr. Gluth as having BPH did not mean that the prostate gland was an abnormal size nor did it mean that Mr. Gluth had any symptom of prostate illness or urinary tract illness." (J.A. 44-45). The district court ultimately entered judgment in favor of Gluth, ordering that Gluth "be paid his benefits for surgery, hospitalization, and related treatment under the [Plan]." (J.A. 3); see 29 U.S.C. § 1132(a)(1)(B). The district court also awarded Gluth \$30,910.00 in attorney's fees and costs, see 29 U.S.C. § 1132(g)(1), and granted Gluth's opposed motion to add the Trust as a defendant.

II.

*4 At the outset of our review of the district court's decision, we must be mindful of the appropriate standard for judicial review of a decision by the administrator of an ERISA benefits plan to deny a claim for benefits. Unless an ERISA benefits plan expressly gives its administrator discretionary authority to determine eligibility for benefits or to construe its terms, a reviewing court uses a *de novo* standard of review. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989). If an ERISA benefits plan does give its administrator discretionary authority to determine eligibility for benefits or to construe its terms, a reviewing court may only reverse the denial of benefits upon a conclusion that the administrator abused its discretion. See *id.* at 111; *Bernstein v. Capital Care, Inc.*, 70 F.3d 783, 787 (4th Cir.1995). Under the abuse of discretion standard of review, a reviewing court should not disturb the administrator's decision if it is reasonable. See *id.*; *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1187 (4th Cir.1989). The decision of a plan administrator is reasonable if the decision is: (1) "the result of a deliberate, principled reasoning process" and (2) "supported by substantial evidence." *Bernstein*, 70 F.3d at 787 (quoting *Baker v. United Mine Workers of Am. Health & Retirement Funds*, 929 F.2d 1140, 1144 (6th Cir.1991)). Finally, when reviewing a plan administrator's decision under the abuse of discretion standard, a court may consider only the record that was before the plan administrator at the time the plan administrator reached its decision. See *Shepard v. Enoch Pratt Hosp. v. Travelers Ins. Co.*, 32 F.3d 120, 125 (4th Cir.1994).

The parties do not dispute that the Plan gave the Administrative Committee discretionary authority to make benefit eligibility decisions and to construe the terms of the Plan. Accordingly, the district court was bound to review the Administrative Committee's decision to deny Gluth's claim for abuse of discretion, which it did. Thus, Gluth's eligibility for benefits turns on whether the Administrative Committee abused its discretion in denying Gluth's claim on the basis that his medical expenses were for an illness, BPH, that was medically documented as existing within the twelve months preceding Gluth's effective date of coverage.

On appeal, Wal-Mart and the Trust (collectively the appellants) contend that the district court erred in concluding that the Administrative Committee abused its discretion in denying Gluth's claim. In this regard, the appellants specifically challenge the district court's conclusion that the record before the Administrative Committee lacked substantial evidence that Gluth's medical expenses were for an illness that was medically documented as existing within the twelve months preceding Gluth's effective date of coverage. As part of this challenge, the appellants contend the district court erroneously considered and relied upon evidence that was not before the Administrative Committee. We agree with the appellants on these points.

*5 Initially, we note that the district court erred as a matter of law by considering and relying upon Dr. Lindemann's trial testimony interpreting his own report as not diagnosing Gluth with BPH and Dr. Magura's trial testimony that Gluth did not suffer from any illness, injury or symptom medically documented as existing within the twelve months preceding Gluth's effective date of coverage. Neither Dr. Lindemann's nor Dr. Magura's testimony was before the Administrative Committee at the time that it decided to deny Gluth's claim.

Although it may be appropriate for a court conducting a *de novo* review of a plan administrator's decision denying benefits to consider evidence that was not taken into account by the plan administrator, when a court is constrained to review a plan administrator's decision denying benefits under the abuse of discretion standard, consideration of evidence not before the plan administrator is proscribed. *See Shepard*, 32 F.3d at 125.

When reviewed within the proper scope, the reasonableness of the Administrative Committee's decision to deny Gluth's claim is undeniable. First, rather than relying on its own experience in reviewing the merits of claims for medical expenses, the Administrative Committee sought and obtained the opinion of a medical professional who had experience treating men over fifty. This evinces a principled approach by the Administrative Committee to reviewing the merits of Gluth's claim. *See Bernstein*, 70 F.3d at 788. Thus, the first requirement of the "reasonableness" standard is met.

Second, the Administrative Committee's decision is supported by substantial evidence, satisfying the second requirement of the "reasonableness" standard. *See id.* The Supreme Court has defined substantial evidence as "'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (quoting *Consolidated Edison Co. of New York v. NLRB*, 305 U.S. 197, 229 (1938)). Here, Gluth's claim file contained a medical report dated within the twelve months preceding Gluth's effective date of coverage that noted a BPH 1+ reading from a digital rectal examination. The same report noted an elevated PSA level, with such elevation potentially caused by an enlarged prostate gland and a recommendation that Gluth see a urologist at his earliest convenience due to his elevated PSA level. The claim file also showed that Dr. Lindemann used ICD Code 600, when ICD Code 600 includes benign prostate gland enlargement as a disease. The claim file further showed that Dr. Magura had made a pre and post operative diagnosis of BPH and urinary retention. Finally, the claim file contained Dr. Arkins' professional medical opinion that the medical records contained in the claim file documented that Gluth suffered from an illness, BPH, during the twelve months preceding his effective date of coverage that ultimately necessitated the removal of a large portion of his prostate gland. We have no doubt that a reasonable mind might accept this evidence as adequate to support the conclusion that Gluth's medical expenses were for an illness, BPH, that was medically documented as existing during the twelve months preceding his effective date of coverage. This is especially true in light of the Administrative Committee's authority under the Plan to interpret the meaning of terms in the Plan such as "illness."

*6 In sum, the district court erred as a matter of law in considering evidence not before the Administrative

Committee and in ultimately concluding that the Administrative Committee had abused its discretion in denying Gluth's claim for medical expenses related to his surgery.

III.

We next address the Trust's challenge to the district court's grant of Gluth's opposed motion to amend the complaint post judgment to name it as a defendant. The record is unclear as to why Gluth made such a motion and why the district court granted it over Wal-Mart's objection. Suffice it to say that the district court erred in granting Gluth's motion, because the Trust, as the funding mechanism for the Plan with no control over its administration, is not a proper defendant in this action. *See Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324-25 (9th Cir.1985) (ERISA permits suits to recover benefits only against the employee benefits plan as an entity).⁸

IV.

In conclusion, we vacate the district court's judgment in favor of Gluth, the district court's award of attorney's fees and costs in favor of Gluth and the district court's order adding the Trust as a defendant and remand with instructions to enter judgment in favor of Wal-Mart and the Plan.⁹

VACATED AND REMANDED WITH INSTRUCTIONS

MURNAGHAN, Circuit Judge, concurring:

While I concur in the judgment as validly expressing the current law, it comes to a sorry result bearing in mind ERISA's concern with protecting the interests of plan participants such as Gluth. At trial, the urologist physicians who treated Gluth related their conclusions that at the time of Dr. Lindemann's examination of Gluth, Gluth did not suffer from the BPH illness, but rather suffered from only *benign* prostrate enlargement, which at Gluth's age was not unusual. Crediting Dr. Lindemann's

and Dr. Magura's testimony, the district court found that Gluth did not suffer from a preexisting illness as defined under the terms of the Plan. Rather, Gluth's acute urinary retention was an initial condition, not a secondary condition as a result of his BPH. Notably, the testimony at trial, particularly from Drs. Lindemann and Magura based on their examinations and treatment of Gluth far outweighed Dr. Arkins', a non-urologist, conclusion that Gluth suffered from a preexisting illness based on Dr. Arkin's 2-3 minute review of Gluth's medical file.

Notwithstanding the above, the majority opinion is anchored on the premise that Gluth did not offer any of the explanations of the sort offered by Gluth at trial to the Administrative Committee at the time Fed.R.Civ.P. 21 ("Parties may be dropped or added by order of the court on motion of any party or of its own initiative at any stage of the action and on such terms that are just."). We believe, in the circumstances of this case, granting Gluth's motion is just. *See id.* the Committee reviewed his file and ultimately decided to deny benefits. Thus, reliance is placed on failure of proof before the Administrative Committee to reach a result most likely, as the district court found, incorrect in fact. The apparent incorrectness emerged when the case was tried. I do not contend, however, that the majority opinion conveys the law inaccurately in this area. Application of that law leads to the inescapable conclusion that an Administrative Committee's most likely incorrect decision can outweigh the federal district judge's likely correct decision evidenced at the time of trial provided the Administrative Committee has not abused its discretion in denying benefits. In the instant case, I concur that the evidence before the Administrative Committee at the time of its consideration of Gluth's application adequately supports the Committee's decision to deny benefits. As I stated at the outset of my concurrence, while the result is apparently legally proper, the unfortunate result does not coincide with ERISA's objective that an honest, hard-working employee should receive health benefits when genuinely needed.

All Citations

117 F.3d 1413 (Table), 1997 WL 368625, 21 Employee Benefits Cas. 1353

Footnotes

- 1 The prostate gland of one who suffers from BPH enlarges sufficiently to compress the urethra and cause some overt urinary obstruction, resulting in urinary retention.
- 2 The trust funded the Plan.
- 3 Gluth actually worked for Sam's Wholesale Club, a division of Wal
- 4 Under the terms of the Plan, the Administrative Committee served as its administrator and had discretionary authority to resolve all questions concerning the administration, interpretation or application of the Plan, including, without limitation, discretionary authority to determine eligibility for benefits or to construe the terms of the Plan in conducting the review of an appeal.
- 5 Under the Plan, its medical advisory council was "[t]he group of medical practitioners appointed by the Administrative Committee to assist in the review of medical claims as and when medical expertise is needed." (J.A. 405).
- 6 Apparently, the claim file did not contain a copy of Dr. Magura's report from his September 23, 1992 examination of Gluth. Thus, the claim file did not contain a record documenting Gluth's complaint on that date that within the preceding six months he had experienced a strong need to urinate with little or no urine coming out.
- 7 Dr. Arkins reasoned that Dr. Lindemann would not have noted a BPH 1+ reading from his digital rectal examination of Gluth, if he did not consider Gluth to be suffering from BPH at the time.
- 8 We note that Gluth named the wrong defendant from the beginning by initially bringing this action against his employer, Wal-Mart, who had no control over the administration of the Plan. See *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir.1988) (unless an employer is shown to control administration of an employee benefit plan, it is not a proper defendant in an ERISA action seeking benefits; rather, the plan is the proper party). However, because Wal-Mart proceeded in the litigation without moving for dismissal on that basis, Wal-Mart waived its right to challenge the propriety of Gluth naming it as a defendant. See *id.*
- 9 Gluth moves on appeal to amend his complaint to add the Plan as a defendant. Presumably, this motion was in response to Wal-Mart's argument on appeal that the judgment and the award of attorney's fees and costs should be vacated and the case dismissed due to his suing it rather than the Plan. See *Daniel*, 839 F.2d at 266 (6th Cir.1988).
In an effort to avoid Gluth bringing this same action against the Plan, we grant Gluth's motion on appeal to name the Plan as a defendant. See Fed.R.Civ.P. 21 ("Parties may be dropped or added by order of the court on the motion of any party or of its own initiative at any stage of the action and on such terms that are just."). We believe, in the circumstances of this case, granting Gluth's motion is just. See *id.* the Committee reviewed his file and ultimately decided to deny benefits. Thus, reliance is placed on failure of proof before the Administrative Committee to reach a result most likely, as the district court found, incorrect in fact. The apparent incorrectness emerged when the case was tried. I do not contend, however, that the majority opinion conveys the law inaccurately in this area. Application of that law leads to the inescapable conclusion that an Administrative Committee's most likely incorrect decision can outweigh the federal district judge's likely correct decision evidenced at the time of trial provided the Administrative Committee has not abused its discretion in denying benefits. In the instant case, I concur that the evidence before the Administrative Committee at the time of its consideration of Gluth's application adequately supports the Committee's decision to deny benefits. As I stated at the outset of my concurrence, while the result is apparently legally proper, the unfortunate result does not coincide with ERISA's objective that an honest, hard-working employee should receive health benefits when genuinely needed.

EXHIBIT 3

2013 WL 6326585

United States District court, D.
Maryland, Northern Division.

Charles WINGLER, Plaintiff,

v.

FIDELITY INVESTMENTS, Defendant.

Civil No. WDQ-12-3439.

|
Dec. 2, 2013.

MEMORANDUM OPINION

WILLIAM D. QUARLES, JR., District Judge.

*1 Charles Wingler, Personal Representative of the Estate of Charlene Wingler, sued Fidelity Management Trust Company ("Fidelity") in the Circuit Court for Carroll County, Maryland for payment of benefits under two employee benefit plans. On November 21, 2012, Fidelity removed the action to this Court. Pending is Fidelity's motion to dismiss, and Wingler's motion for leave to file a surreply. For the following reasons, Fidelity's motion to dismiss will be granted. Wingler's motion for leave to file a surreply will be denied.

I. Background¹

A. Factual Background

Charlene Wingler, now deceased, had a 401(k) retirement plan and 403(b) savings plan through her employment with the Catholic Health Initiatives ("CHI") during her lifetime. See ECF No. 1 ¶ 1; ECF No. 1, Exs. B, C. The benefit plans are governed by the Employee Retirement Income Security Act of 1974 ("ERISA").² ECF No. 1, Exs. B, C. The plan beneficiary was the Estate of Charlene Wingler. ECF No. 1 ¶ 3. The personal representative of Charlene Wingler's estate is Charles Wingler. ECF No. 1. The benefits were distributed to Stephanie Wilking, who was the previous personal representative of the estate. *Id.* ¶ 4.

B. 401(k) Plan

The 401(k) Plan is the "Catholic Health Initiatives 401(k) Plan." ECF No. 1, Ex. C; ECF No. 22-

3 (hereinafter "the 401(k) Plan"). The 401(k) Plan designates "CHI Retirement Plans Subcommittee or any other entity appointed by the Catholic Health Initiatives Board of Stewardship Trustees as its designee," as the Administrator of the plan. *Id.* § 1.01(c). The 401(k) Plan provides that the Administrator is the "named fiduciary" with "the powers and responsibilities with respect to the management and operation of the Plan." *Id.* § 19.04. The Administrator "has the full power and the full responsibility to administer the Plan." *Id.* § 19.01.

The "Fidelity Management Trust Company" is designated as the Trustee. *Id.* § 1.03. The 401(k) Plan provides for the powers of the Trustee such that "The Trustee shall have no discretion or authority with respect to the investment of the funds contributed to it," and the Trustee exercises its powers "solely as a directed trustee in accordance with the written direction of the Employer." *Id.* § 20.04. The Trustee "shall make such distributions from the Trust Fund as the Employer or Administrator may direct." *Id.* § 20.07.

C. 403(b) Plan

The 403(b) Plan is the "Catholic Health Initiatives (ERISA) Employee Savings Plan." ECF No. 1, Ex. B; ECF No. 22-4 (hereinafter "the 403(b) Plan"). The Plan Administrator is defined as "the Catholic Health Initiatives Retirement Plans Subcommittee, or any other entity appointed by the CHI Board of Stewardship Trustees, from time to time, to act as the Plan Administrator." *Id.* § 1.77 at BPD-6. The 403(b) Plan designates "Fidelity Investments" as the Vendor. *Id.* § 32 at AA-11. A Vendor is "the Custodian or entity holding the Plan assets or the provider of any Funding Vehicle holding all or part of the Participant's Account." *Id.* § 1.106 at BPD-8.

*2 The "powers and duties" of the Plan Administrator include "direct[ing] the Vendor regarding the crediting and distribution of a Funding Vehicle." *Id.* § 7.02(c) at BPD-20. With regards to the distribution of benefits upon the death of a Participant, the 403(b) Plan states:

In the event of the Participant's death (whether the death occurs before or after Severance

from Employment), the *Plan Administrator*, subject to the requirements of Sections 6.02 or to a beneficiary's written election, *must direct the Vendor to distribute or commence distribution of the deceased Participant's Vested Account Balance*, as soon as administratively practicable following the date on which the Plan Administrator receives notification of, or otherwise confirms, the Participant's death.

Id. § 6.01(a) at BPD-16. The 403(b) Plan also designates "the Catholic Health Initiatives Retirement Plan Subcommittee or any other entity appointed by the Catholic Health Initiatives Board of Stewardship Trustees as its designee, from time to time" as the "Named Fiduciary of the Plan." *Id.* § 7.01(g) at BPD-20. "The Named Fiduciary has sole responsibility for the management and control of the Plan." *Id.*

D. Procedural History

On October 19, 2012, Wingler sued Fidelity in the Circuit Court for Carroll County, Maryland to recover the benefits distributed from the 401(k) Plan and the 403(b) Plan. ECF No. 2; ECF No. 1.³ On November 21, 2012, Fidelity removed the action to this Court. ECF No. 2. On March 1, 2013, Fidelity moved to dismiss the complaint. ECF No. 22. On March 8, 2013, Wingler opposed the motion. ECF No. 23. On March 22, 2013, Fidelity replied. ECF No. 24. On April 17, 2013, Wingler moved for leave to file a surreply. ECF No. 27. On April 23, 2013, Fidelity opposed the motion. ECF No. 30.

II. Analysis

A. Legal Standard

Under Fed.R.Civ.P. 12(b)(6), an action may be dismissed for failure to state a claim upon which relief can be granted. Rule 12(b)(6) tests the legal sufficiency of a complaint, but does not "resolve contests surrounding the facts, the merits of a claim, or the applicability of defenses." *Presley v. City of Charlottesville*, 464 F.3d 480, 483 (4th Cir.2006).

The Court bears in mind that Rule 8(a)(2) requires only a "short and plain statement of the claim showing that the pleader is entitled to relief." *Migdal v. Rowe Price-Fleming Int'l Inc.*, 248 F.3d 321, 325-26 (4th Cir.2001). Although Rule 8's notice-pleading requirements are "not onerous," the plaintiff must allege facts that support each element of the claim advanced. *Bass v. E.I. DuPont de Nemours & Co.*, 324 F.3d 761, 764-65 (4th Cir.2003). These facts must be sufficient to "state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007).

This requires that the plaintiff do more than "plead[] facts that are 'merely consistent with a defendant's liability'"; the facts pled must "allow[] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 557). The complaint must not only allege but also "show" that the plaintiff is entitled to relief. *Id.* at 679 (internal quotation marks omitted). "Whe[n] the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged—but it has not shown—that the pleader is entitled to relief." *Id.* (internal quotation marks and alteration omitted).

B. Fidelity's Motion to Dismiss

*3 Fidelity asserts that Wingler's ERISA claim for benefits must be dismissed because Fidelity has no decision-making authority, and therefore is not a proper party defendant. ECF No. 22-1 at 1. Under ERISA § 502(a), "a participant or beneficiary" may sue "to recover benefits due him under the terms of the plan." 29 U.S.C. § 1132(a)(1). The proper defendants in an ERISA benefits action are the benefit plan and the entity with discretionary decision-making authority.⁴

The Catholic Health Initiatives Retirement Plans Subcommittee, (hereinafter the "CHI Subcommittee"), is the Administrator and Named Fiduciary of the 401(k) Plan and the 403(b) Plan. *See* 401(k) Plan §§ 1.01(c), 19.04; 403(b) Plan §§ 1.77 at BPD-6, 7.01(g) at BPD-20. The CHI Subcommittee has the sole power and responsibility to manage and control the plans. *See* 401(k) Plan §§ 19.01, 19.04; 403(b) Plan § 7.01(g) at BPD-20. As the Trustee of the 401(k) Plan, Fidelity acts "solely as a directed trustee," and makes distributions at the direction of the CHI Subcommittee. *See* 401(k) Plan §§ 20.04, 20.07. As the Vender of the 403(b) Plan, Fidelity

makes distributions of benefits at the direction of the CHI Subcommittee. *See* 403(b) Plan § 6.01(a) at BPD–16. Fidelity is not an entity with discretionary decision-making authority in either plan, and instead acts at the direction of the administrator and fiduciary of each plan, the CHI Subcommittee. Accordingly, Fidelity is not a proper defendant.

In an effort to salvage his ERISA benefits claim against Fidelity, Wingler alleges for the first time in his Opposition that the plan “was administered by Catholic Charities in name only but was actually administered and all of the benefits paid to maintained by and otherwise dealt with by the defendant Fidelity in its capacity as fiduciary.” ECF No. 23 at 1. Wingler also alleges in his Opposition that the improper payment of benefits by Fidelity makes it an entity with discretionary decision-making authority over the denial of ERISA benefits. *See id.* at 3. However, Wingler is bound by the allegations contained in his complaint, and he cannot amend his complaint through his opposition brief.⁵ Additionally, contrary to the new allegations in Wingler's Opposition, the provisions of both plans demonstrate that Fidelity is not a fiduciary or a plan administrator. *See* 401(k) Plan §§ 1.01(c), 19.04; 403(b) Plan §§ 1.77 at BPD–6, 7.01(g) at BPD–20. Because Fidelity is not a proper defendant for Wingler's claim for ERISA benefits, the claim will be dismissed.⁶

C. Wingler's Motion for Leave to File a Surreply

Wingler seeks to file a surreply because “[u]pon reviewing and contemplating the content of the defendant's response,” he “determined that a further reply ... was appropriate.” ECF No. 27–1. Fidelity argues that it raised no new matters in its reply. ECF No. 30 at 2.

Unless otherwise ordered by the Court, a party generally may not file a surreply. Local Rule 105.2(a). Leave to file a surreply may be granted when the movant otherwise would be unable to contest matters presented for the first time in the opposing party's reply. *Khoury v. Meserve*, 268 F.Supp.2d 600, 605 (D.Md.2003), *aff'd*, 85 F. App'x 960 (4th Cir.2004).

*4 In its motion to dismiss, Fidelity argued that Wingler's claim should be dismissed because Fidelity is not a proper defendant, and Wingler cannot assert a claim for breach of fiduciary duties. ECF No. 22 at 1. Fidelity's reply does not raise new legal arguments. The reply responded to Wingler's arguments that Fidelity is a proper defendant, distinguished the cases cited by Wingler, addressed why the Court should disregard any new allegations in Wingler's opposition, and argued that any discussion of the merits in Wingler's opposition should also be disregarded. *See* ECF No. 24; ECF No. 30 at 3. Wingler's proposed surreply reiterates the arguments made in his opposition and improperly addresses the merits of his claim. *See* ECF No. 27 at 1–2. The motion for leave to file a surreply will be denied.

III. Conclusion

For the reasons stated above, Fidelity's motion to dismiss will be granted. Wingler's motion for leave to file a surreply will be denied.

All Citations

Not Reported in F.Supp.2d, 2013 WL 6326585, 57 Employee Benefits Cas. 1275

Footnotes

- 1 On a motion to dismiss, the well-pled allegations in the complaint are accepted as true. *Brockington v. Boykins*, 637 F.3d 503, 505 (4th Cir.2011). The Court will consider the pleadings, matters of public record, and documents attached to the motions that are integral to the complaint and whose authenticity is not disputed. *See Phillips v. Pitt Cnty. Mem'l Hosp.*, 572 F.3d 176, 180 (4th Cir.2009).
- 2 29 U.S.C. §§ 1001, *et seq.*
- 3 Wingler identified the Defendant in the Complaint as “Fidelity Investments, a subsidiary of Fidelity Investments Institution Services Company, Inc.” ECF No. 2. Fidelity Investments is the trade name of a group of companies, including Fidelity Management Trust Company which performs the services for the plans at issue. *See* ECF No. 22–1 at 6 n.1.
- 4 *See, e.g., Gluth v. Wal-Mart Stores, Inc.*, No. 96–1307, 1997 WL 368625, at *6 (4th Cir. July 3, 1997) (the plan's trust, as a funding mechanism for the plan with no control over its administration, is not a proper defendant in an ERISA benefits action); *Trotter v. Kennedy Krieger Inst., Inc.*, No. 11–3422–JKB, 2012 WL 3638778 (D.Md. August 22, 2012) (“The law in this District is clear that the only proper party defendant to an ERISA action for benefits is the entity which

holds the discretionary decision-making authority over the denial of ERISA benefits.") (internal quotation marks omitted); *Valderrama v. Honeywell TSI Aerospace Servs.*, No. RWT-09-CV-2114, 2010 WL 2802132, at *6 (D.Md. July 14, 2010) ("A suit to recover ERISA benefits may be brought only against the plan, the plan administrator, or a plan fiduciary."); *Ankney v. Metro. Life Ins.*, 438 F.Supp.2d 566, 574 (D.Md.2006) (proper defendant is the entity with discretionary decision-making authority over the denial of benefits).

5 See *Butts v. Encore Mktg. Int'l*, No. PJM-10-3244, 2012 WL 3257595, at *5 (D.Md. August 7, 2012) (quoting *Zachair, Ltd. v. Driggs*, 965 F.Supp. 741, 748 n.4 (D.Md.1997)) (internal quotation marks omitted).

6 Fidelity also argues that, to the extent Wingler alleges a claim for breach of fiduciary duty under ERISA, the claim is unauthorized because ERISA § 502(a) provides an exclusive remedy for a claim for benefits. See ECF No. 22-1 at 14. Wingler apparently concedes this argument because he did not refute it in his opposition to the motion to dismiss. See, e.g., *Grinage v. Mylan Pharm., Inc.*, 840 F.Supp. 862, 867 n.2 (D.Md.2011) (plaintiff abandoned a claim when her response in opposition failed to address the defendant's challenge to that claim in its motion to dismiss).

EXHIBIT 4

Appendix G

The Time Required for CON Project Review

APPENDIX G: Projects Filed in July 2011 or Later for which Final Action by MHCC or Withdrawal by the Applicant has Occurred
Length of Project Review CORRECTED MAY 2018

Type of Project (Basis for Review)	Date of Application Filing	Date of Docketing of Application	Date of Final Action or Withdrawal	Type of Review	Project Cost Estimate	Application Filing to Docketing (Days)	Docketing to Action or Withdrawal (Days)	Application Filing to Action or Withdrawal (Days)
	7/28/2011	10/7/2011	7/18/2013	Contested	\$1,075,211	71	649	720
Change in bed capacity of a general hospice								
Introduce acute rehabilitation services at a general hospital	4/6/2012	6/15/2012	8/29/13*	Uncontested	\$7,557,170	70	440	510
Capital expenditure by a general hospital	7/6/2012	10/5/2012	2/21/2013	Uncontested	\$23,539,350	91	139	230
Change in bed capacity of an alcohol and drug abuse ICF	1/25/2013	5/17/2013	9/19/2013	Uncontested	\$20,928,056	112	125	237
Change in bed capacity of a general hospice	6/21/2013	10/4/2013	6/19/2014	Uncontested	\$458,343	105	258	363
Relocation of an ambulatory surgery center and addition of an operating room	7/5/2013	9/20/2013	11/21/2013	Uncontested	\$891,000	77	62	139
Change in bed capacity of a general hospice	9/30/2013	3/21/2014	12/18/2014	Contested	\$1,388,372	172	272	444
Relocation of a general hospital	10/4/2013	12/12/2014	12/17/2015	Contested	\$400,198,988	69	370	439
Establishment of a comprehensive care facility	10/4/2013	2/7/2014	9/3/15*	Contested	\$13,013,500	126	573	699
Establishment of a comprehensive care facility	10/4/2013	2/7/2014	4/17/2014	Uncontested	\$30,995,328	126	69	195
Relocation of a general hospital	10/4/2013	4/3/2015	10/20/2016	Contested	\$543,000,000	546	565	1,111
Relocation of an ambulatory surgery center and addition of two operating rooms	1/31/2014	4/4/2014	7/17/2014	Uncontested	\$3,637,265	63	104	167
Establishment of a general hospice	6/2/2014	8/8/2014	9/18/2014	Uncontested	\$225,100	67	41	108
Change in bed capacity of a comprehensive care facility	9/12/2014	11/14/2014	2/19/2015	Uncontested	\$25,025,000	63	97	160
Change in bed capacity of a comprehensive care facility	9/12/2014	1/23/2015	3/19/15*	Uncontested	\$160,000	133	55	188
Change in bed capacity of a general hospice	10/29/2014	1/23/2015	3/19/2015	Uncontested	\$7,015,000	86	55	141
Establishment of a residential treatment center	10/29/2014	10/16/2015	4/7/17*	Contested	\$3,693,760	352	539	891
Change in bed capacity of a comprehensive care facility	2/6/2015	4/3/2015	7/16/2015	Uncontested	\$5,807,345	56	104	160
Establishment of a comprehensive care facility	2/6/2015	4/3/2015	6/18/2015	Uncontested	\$12,215,376	56	76	132
Introduce cardiac surgery at a general hospital	2/20/2015	6/26/2015	3/23/2017	Contested	\$2,500,381	126	608	734
Introduce cardiac surgery at a general hospital	2/20/2015	6/26/2015	3/23/2017	Contested	\$1,259,117	126	608	734
Establish an alcohol and drug abuse ICF	3/27/2015	10/16/2015	1/26/2017	Contested	\$16,783,294	203	468	671
Establish an alcohol and drug abuse ICF	3/27/2015	10/16/2015	12/15/2016	Contested	\$7,388,582	203	436	639

Establish an alcohol and drug abuse ICF	3/27/2015	10/16/2015	1/26/2016	Contested	\$12,239,219	203	468	671
Change in bed capacity of a comprehensive care facility	4/10/2015	6/12/2015	9/17/2015	Uncontested	\$3,680,000	63	97	160
Relocation of a special psychiatric hospital	4/10/2015	9/18/2015	9/20/2016	Uncontested	\$96,532,907	161	368	529
Capital expenditure by a general hospital	4/10/2015	9/4/2015	5/19/2016	Uncontested	\$207,251,608	147	258	405
Establish an ambulatory surgery center	8/7/2015	12/11/2015	9/20/2016	Uncontested	\$16,340,840	128	283	411
Capital expenditure by a general hospital	10/9/2015	3/4/2016	11/17/2016	Uncontested	\$51,654,138	147	258	405
Change in condition of operation of a residential treatment center	12/22/2015	5/13/2016	7/21/2016	Uncontested	\$80,000	143	69	212
Addition of an operating room by an ambulatory surgical facility	2/5/2016	5/13/2016	6/17/2016	Uncontested	\$2,253,239	98	35	133
Establish an alcohol and drug abuse ICF	3/21/2016	6/10/2016	12/15/2016	Uncontested	\$1,936,275	81	188	269
Capital expenditure by a comprehensive care facility	4/8/2016	1/16/2017	5/18/2017	Uncontested	\$29,691,826	283	122	405
Change in bed capacity of a comprehensive care facility	5/6/2016	7/8/2016	10/20/2016	Uncontested	\$10,195,736	63	104	167
Addition of an operating room by an ambulatory surgical facility	7/8/2016	9/16/2016	12/15/2016	Uncontested	\$266,397	70	91	161
Change in bed capacity of a comprehensive care facility	8/5/2016	10/28/2016	2/16/2017	Uncontested	\$5,457,500	84	111	195
Capital expenditure by a general hospital	8/5/2016	12/9/2016	6/15/2017	Uncontested	\$70,000,000	126	188	314
Addition of an operating room by an ambulatory surgical facility	1/6/2017	3/3/2017	4/20/2017	Uncontested	\$1,998,352	56	48	104
Addition of jurisdictions to the service area of a home health agency	3/10/2017	6/9/2017	7/20/2017	Uncontested	\$34,000	91	406	497
Addition of an operating room by an ambulatory surgical facility	2/3/2017	4/28/2017	6/15/2017	Uncontested	\$216,925	84	48	132
Addition of an operating room by an ambulatory surgical facility	2/3/2017	4/28/2017	7/20/2017	Uncontested	\$741,499	84	83	167
Establishment of a special psychiatric hospital	3/28/2016	10/14/2016	4/19/2018	Contested	\$24,984,795	200	552	752
Capital expenditure by a comprehensive care facility	4/7/2017	12/8/2017	2/15/2018	Uncontested	\$14,273,000	245	69	314
Change in bed capacity of a comprehensive care facility	4/7/2017	7/7/2017	9/19/2017	Uncontested	\$6,799,182	91	74	165
Change in bed capacity of a comprehensive care facility	4/7/2017	9/1/2017	10/19/2017	Uncontested	\$138,000	147	48	195
Addition of an operating room by an ambulatory surgical facility	7/7/2017	9/29/2017	11/16/2017	Uncontested	\$1,759,618	84	48	132
Capital expenditure exceeding threshold by a general hospice	8/14/2017	10/13/2017	12/21/2017	Uncontested	\$7,998,114	60	69	129
Addition of an operating room by an ambulatory surgical facility	10/6/2017	1/19/2018	3/15/2018	Uncontested	\$183,031	105	55	160
Capital expenditure by a comprehensive care facility	11/13/2017	3/16/2018	4/19/2018	Uncontested	\$19,219,869	123	34	157

*Application withdrawn following negative recommendation by staff or Commissioner/Reviewer

49 Projects Filed between July 2011 and November 2017 that obtained final action by MHCC or were withdrawn

Average number of days from application filing to docketing of application:	128 (4.2 months)
Average number of days from docketing to final action or withdrawal:	222 (7.3 months)
Average number of days from application filing to final action or withdrawal:	350 (11.5 months)
Median number of days from application filing to docketing of application:	105 (3.5 months)
Median number of days from docketing to final action or withdrawal	117 (3.8 months)
Median number of days from application filing to final action or withdrawal:	222 (7.3 months)

EXHIBIT 5

Johns Hopkins is Simplifying Our Billing Statement

as of July 23rd




For services after July 23, 2018, you will receive one bill for your care at Johns Hopkins Medicine.

We are also consolidating our call centers so that you have one place to call for questions about your bills (including Behavioral Health). Our Customer Service can be reached at **1-855-662-3017** select 0. If you have a balance from visits that occurred before July 23, 2018, you may still receive multiple bills until those balances are paid. Please pay these by following the instructions listed on any bills you receive.

This new bill has been designed with you in mind to help you better understand your financial responsibility.

Paying Your New Bill

You will be able to pay your bill in three ways:

-  Online at **mychart.hopkinsmedicine.org**
-  By phone at **1-855-662-3017** and select option 1.
-  By mailing in your check or money order payable to Johns Hopkins Medicine, along with the coupon at the bottom of your statement. Please write your guarantor number in the memo field.

Payment Plans

If you are unable to pay your amount due in full and would like to establish a monthly payment plan, call us at 1-855-662-3017 and select option 0 to speak with a Customer Service Agent.

Financial Assistance

If you are having trouble making your payments you may be eligible for financial assistance. For more information please contact us at 1-855-662-3017 and select option 0.

Information Changes

If you have changes to your name, address or insurance information, call Customer Service at 1-855-662-3017 and select option 0.

Questions?

Customer Service is available to answer your questions at 1-855-662-3017 and select option 0. Our team is available Monday through Friday from 8:30 a.m. to 4:30 p.m. You can also contact us through your MyChart via the message center by selecting "Billing Question". If you do not have a MyChart Account, ask about it at your next appointment with your Johns Hopkins Medicine provider.

MyChart

You will be able to view test results, access your health record, make appointments, review your statements, enroll in electronic statements and more through our secure online portal.

Thank you for choosing Johns Hopkins for your care.

Johns Hopkins is Simplifying Our Billing Statement

as of July 23rd

Your New Bill

Statement of Services as of 04/17/18 Page 1 of 2

1 Patient Name: Singlebillingoffice,Testtwo
Guarantor Number: 2216212
Statement Date: 04/17/18

2 Account Summary
Balance Due Not on a Payment Plan: \$723.07
Amount Due: \$723.07
Amount Due without Discount If Payment not received by 05/17/18: \$728.61

3 Payment Plans
If you are unable to pay your amount due in full and would like to establish a monthly payment plan, please contact us at 1 (855) 662-3017 and select option 0.

4 Financial Assistance
If you are unable to pay, you may be eligible for financial assistance. For more information please contact us at 1 (855) 662-3017 and select option 0.

5 Payment Options
You may pay your bill anytime 24/7 online, by mail or by phone:
To pay easily and securely online, view your bill details, access your health record, make appointments, and enroll in electronic statements, sign up for MyChart at mychart.hopkinsmedicine.org
Activation Code: 69H42-048EY
To pay by phone call 1 (855) 662-3017 and select option 1.
To mail in the payment, please make your check payable to Johns Hopkins Medicine, write your guarantor number in the check memo field, and include the attached coupon.

Questions about your bill?
Call 1 (855) 662-3017 and select option 0.
Hours of Operation: 8:30am-4:30pm Mon-Fri
Send us a message using mychart.hopkinsmedicine.org
Other Questions? Check our billing FAQs on MyChart.

Johns Hopkins Medicine
Johns Hopkins Medicine
P.O. Box 3333
Toledo, OH 43607-1511
Patient: Singlebillingoffice,Testtwo

Statement Date: 04/17/18 Due Date: 05/17/18 Guarantor Number: 2216212
Amount Due: \$723.07
Amount Enclosed:
VISA MASTERCARD DISCOVER AMEX
To pay easily and securely by credit card, go to mychart.hopkinsmedicine.org or call 1 (855) 662-3017 and select option 1 or for Customer Service option 0.

Statement of Services as of 04/17/18 Page 2 of 2

7 Hospital Services
Patient Name: Singlebillingoffice,Testtwo
Service #: 4000006008
Emergency Room From: 12/04/17 To: 12/04/17
Johns Hopkins Bayview Medical Center
Primary Payor: AETNA
Secondary Payor:
Important message about your account: Our records show that you are now responsible for the account balance. If paid within 30 days you will receive a 1% discount. Thank you for choosing Johns Hopkins Medicine for your healthcare needs.

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
	Operating Room Services	\$482.54			
	Emergency Room	\$83.03			
	Patient Adjustments			\$5.54	
	Service Total	\$565.57	\$0.00	\$5.54	\$548.07

8 Physician Services
Patient Name: Singlebillingoffice,Testtwo
Service #: 8000108059
Outpatient
The Johns Hopkins Hospital
Primary Payor: AETNA
Secondary Payor:
Important message about your account: We have not received payment on your account. Please make your payment within 15 days from the date of this notice to remain in good standing.

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
12/04/17	OFFICE/OUTPAT VISIT,EST,LEVL III	\$175.00			
	Service Total	\$175.00	\$0.00	\$0.00	\$175.00
	Totals	\$728.61	\$0.00	\$5.54	\$723.07

- 1 Guarantor Number** – a unique number that identifies all accounts that are related financially. This number can be used to pay for multiple visits/dates of service via MyChart and via phone.
- 2 Account Summary** – this section summarizes the amount due from both physician and hospital. If you are on a payment plan, it will show you the payment plan amount due and the amount due if you do not pay within 30 days of receipt of this statement. If you are not on a payment plan it will show a zero balance for payment plan due and the balance due not on a payment plan.
- 3 Payment Plan/Payment Agreement Status** – in this section is the number to call if you are unable to pay your amount due in full and would like to establish a monthly payment plan. If you are already on a payment plan, the Payment Agreement Status reflects the pay arrangements that you have already agreed upon.
- 4 Financial Assistance** – if you are unable to pay, you may be eligible for assistance. Please contact us to get more information on how to apply.
- 5 Payment Options** – the ways you can pay your bill, including MyChart, by phone by dialing 1-855-662-3017 and select option 1 or via the mail. If you do not want to create a MyChart account you can pay as a guest.
- 6 Payment Coupon** – indicate the amount you are paying and detach and mail the coupon with the information completed by the due date. To pay easily and securely by credit card go to mychart.hopkinsmedicine.org or dial 1-855-662-3017 and select option 1.
- 7 Hospital Services** – this section details charges associated with the facility where you received care, such as emergency room, clinic, radiology or laboratory services. It also describes the services provided, the charges for each service, payments, adjustments and the patient balance due.
- 8 Physician Services** – this section details charges associated with the providers that rendered services, such as a physician visit or another professional service provided. It also describes the services provided, the charges for each service, payments, adjustments and the patient balance due.
- 9 Service Number** – individual account number tied to a specific visit/date of service. Each visit has a unique service number. This number can be used to pay via MyChart and phone.

EXHIBIT 6

Johns Hopkins Bayview Medical Center

patient handbook



JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

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From the President Our Commitment to Patient- and Family-Centered Care

We promise to care for you, and about you, in a manner that places you and your family at the center of everything we do.

We recognize you as an individual with individual needs and expectations. We recognize the importance of your family in your healing process.

Our commitment to patient- and family-centered care includes the exchange of relevant, timely and accurate communications; multidisciplinary collaboration and teamwork; continuity throughout your transitions of care; and coordination of care that meets your needs and preferences for health care, all in a culture that values caring and service.

Warm regards,

Richard Bennett

Richard Bennett, M.D., President

WELCOME

Our Vision

Johns Hopkins Bayview Medical Center is widely recognized for innovation and excellence in clinical education and research in medicine. As a leading academic medical center, we will provide an enriching environment for our employees and an exceptional health care experience for our patients and their families.

Our Core Values

- Excellence & Discovery (*Be the best*)
- Leadership & Integrity (*Be a role model*)
- Diversity & Inclusion (*Be open*)
- Respect & Collegiality (*Be kind*)

Our Mission

Johns Hopkins Bayview Medical Center, a member of Johns Hopkins Medicine, provides compassionate health care that is focused on the uniqueness and dignity of each person we serve. We offer this care in an environment that promotes, embraces and honors the diversity of our global community. With a rich and long tradition of medical care, education and research, we are dedicated to providing and advancing medicine that is respectful and nurturing of the lives of those we touch.

NOTE: If you are in the hospital and calling the above numbers listed in this guide, please dial "0" and the four digit extension.

You're Special To Us

Our patient care teams value the individuality of each patient. Everyone is committed to meeting your needs and helping you feel. We recognize that you and your family play important roles in your care and healing process, and it helps us to know how we can meet your needs. Please talk to your health care provider if you want to learn more about or request services, such as:

- Interpreters
- Spiritual care
- Dietary preferences
- Cultural needs
- Pain management

When your patient care team is aware of your needs and preferences, we can work with you and your family to ensure your safety and comfort. This patient information handbook is filled with information about the special services we offer, patient rights and responsibilities, and patient safety and security measures.

We value the diversity of our patients and strive to provide culturally competent care to everyone.

Our Privacy Practices

Privacy and Confidentiality

We are committed to protecting your medical information. We create a record of the care and services you receive for use in your care and treatment. We are required by law to make sure that your medical information is protected. We also are required to give you notice describing your legal duties and privacy practices with respect to your medical information. Our privacy practices are described in the Johns Hopkins Notice of Privacy Practices, a booklet that explains how this obligation will be followed by all health care professionals, trainees, students, staff, volunteers and business associates of the Johns Hopkins organizations. To obtain a copy of this booklet, call the Admitting Office at 410-550-0830.

If you have a patient privacy concern, please call the Johns Hopkins Privacy Officer at 410-735-6509, Monday through Friday between 8:30 a.m. and 5 p.m.

Patient Rights and Responsibilities

To promote patient safety, we encourage you to speak openly with your health care team, be well informed, and take part in care decisions and treatment choices. Join us as active members of your health care team by reviewing the rights and responsibilities listed below for patients and patient representatives.

YOU OR YOUR DESIGNEE HAVE THE RIGHT TO:

Respectful and Safe Care

- 1 Be given considerate, respectful and compassionate care.
- 2 Have a family member/friend and your doctor notified when you are admitted to the hospital.
- 3 Be given care in a safe environment, free from abuse and neglect (verbal, mental, physical or sexual).
- 4 Have a medical screening exam and be provided stabilizing treatment for emergency medical conditions and labor.
- 5 Be free from restraints and seclusion unless needed for safety.
- 6 Know the names and jobs of the people who care for you.
- 7 Know when students, residents or other trainees are involved in your care.
- 8 Have your culture and personal values, beliefs and wishes respected.
- 9 Have access to spiritual services.
- 10 Have conversations with the Ethics Service about issues related to your care.

- 11 Be treated without discrimination based on race, color, national origin, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, ethnicity, language or ability to pay.
- 12 Be given a list of protective and advocacy services, when needed. These services help certain patients (e.g., children, elderly, disabled) exercise their rights and protect them from abuse and neglect.
- 13 Ask for an estimate of hospital charges before care is provided.

Effective Communication and Participation in Your Care

- 14 Get information in a way you can understand. This includes sign language and foreign language interpreters and vision, speech and hearing aids provided free of charge.

- 15 Get information from your doctor/provider about:
 - your diagnosis
 - your test results
 - outcomes of care
 - unanticipated outcomes of care

- 16 Be involved in your plan of care and discharge plan or request a discharge plan evaluation at any time.

- 17 Involve your family in decisions about care.
- 18 Ask questions and get a timely response to your questions or requests.

- 19 Have your pain managed.
- 20 Refuse care.

- 21 Have someone with you for emotional support, unless that person interferes with your or others' rights, safety or health.
- 22 Ask for a chaperone to be with you during exams, tests or procedures.

- 23 Choose your support person and visitors and change your mind about who may visit.
- 24 Select someone to make health care decisions for you if at some point you are unable to make those decisions (and have all patient rights apply to that person).

End of Life Decisions

- 25 Create or change an advance directive (also known as a living will or durable power of attorney for health care).
- 26 Have your organ donation wishes known and honored, if possible.

Informed Consent

- 27 Give permission (informed consent) before any non-emergency care is provided, including:
 - risks and benefits of your treatment
 - alternatives to that treatment
 - risks and benefits of those alternatives
- 28 Agree or refuse to be part of a research study without affecting your care.
- 29 Agree or refuse to allow pictures for purposes other than your care.

Privacy and Confidentiality

- 30 Have privacy and confidential treatment and communication about your care.
- 31 Be given a copy of the HIPAA Notice of Privacy Practices.

Complaints and Grievances

- 32 Complain and have your complaint reviewed without affecting your care. If you have a problem or complaint, you may talk to your doctor, nurse manager or a department manager.
- 33 You may also contact the Office of Patient Experiences at 410-550-0626.
- 34 If your issue is not resolved to your satisfaction, other external groups you may contact include:
 - Hospital's Quality Improvement Organization (QIO) for coverage decisions or to appeal a premature discharge:
 - KEPRO
 - Organization for Beneficiary Family Centered Care (BFCC-QIO)
 - 5201 West Kennedy Blvd.
 - Suite 900
 - Tampa, FL 33609
 - 1-844-455-8708

- State Agency:
 - Maryland Department of Health & Mental Hygiene
 - Office of Health Care Quality Hospital Complaint Unit
 - Spring Grove Hospital Center
 - Bland Bryan Building
 - 55 Wake Avenue
 - Crofton, Maryland 21228
 - Toll free: 1-877-402-8218

- Accredited Agency:
 - The Joint Commission Office of Quality and Patient Safety
 - One Renaissance Blvd.
 - Oakbrook Terrace, IL 60181
 - 1-800-994-6610
 - patientreport@jointcommission.org

- To address discrimination concerns, you may also file a civil rights complaint with the U.S. Department of Health and Human Services:

Office for Civil Rights
200 Independence Ave., SW
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)
OCR@hhs.gov
Complaint forms are available at:
<http://www.hhs.gov/office/foi/index.html>

You Have the Responsibility to:

- 1 Provide accurate and complete information about your health, address, telephone number, date of birth, insurance carrier and employer.
- 2 Call if you cannot keep your appointment.
- 3 Be respectful of your hospital team, from the doctors, nurses and technicians to the people who deliver your meals and the cleaning crews.
- 4 Be considerate in language and conduct of other people and property, including being mindful of noise levels, privacy and number of visitors.
- 5 Be in control of your behavior if feeling angry.
- 6 Give us a copy of your advance directive.
- 7 Ask questions if there is anything you do not understand.
- 8 Report unexpected changes in your health.
- 9 Follow hospital rules.
- 10 Take responsibility for the consequences of refusing care or not following instructions.
- 11 Leave valuables at home.
- 12 Keep all information about hospital staff or other patients private.
- 13 Do not take pictures, videos or recordings without permission from hospital staff.
- 14 Pay your bills or work with us to find funding to meet your financial obligations

YOUR HEALTH AND SAFETY

Our health care partnership begins with our commitment to your safety. Patients who are involved with their care in the hospital tend to do better. By working together with your health care team, you can lower your risk of injury and make your stay safer.

Working Together Around the Clock

• Hourly Rounding

At Johns Hopkins Bayview, our goal is to visit you (round) every hour to check on you and address any needs you may have such as pain and personal comfort.

• Bedside Shift Report

To promote good communications between your nurses, and you and your family, we want you to join with your nurses in Bedside Shift Report. At this time your nurse who is going off duty shares important information about you with the nurse coming on duty—at your bedside. Bedside Shift Report helps make sure you get high-quality care. If you have questions or concerns about your care, Bedside Shift Report provides a good time to raise them. Ask your nurse if you have questions about the report.

• Communication Board

You have a communication board in your room. On it, your health care team will write the names of staff who will be working with you each day. You can review your communication board with your health care team during the bedside shift report.

Speak Up!

Speak up if you have any questions or concerns.

Pay attention to the care you are receiving.

Educate yourself so you fully understand your diagnosis and treatment.

Ask a trusted family member or friend to be your advocate.

Know about your medicine. Medicine errors are the most common health care mistakes.

Use an accredited health care facility, like Johns Hopkins Bayview, that has completed rigorous inspections to ensure safety and quality.

Participate in all decisions about your treatment plan.

Hand Hygiene

Hand hygiene is our top priority and the number one intervention to prevent health care-associated infections. We perform surveillance for hand hygiene compliance using a "secret shopper" methodology. Unknown observers monitor hand hygiene practices on all of our units using standardized definitions and data collection procedures. There also is a direct feedback program with known monitors who address, educate and take the name of staff at the moment they are observed not appropriately performing hand hygiene. We monitor hand hygiene compliance upon each entry to and exit from a patient care room or area.

Our Partnership Pledge

We take a team approach to your safety.

We pledge to:

- Coordinate your care.
- Explain your care and treatment.
- Listen to your questions or concerns.
- Ask if you have safety concerns and take steps to address them, as possible.
- Ask about your pain often and keep you as comfortable as possible.
- Check your identification before any medication, treatment or procedure is given.
- Label all lab samples in your presence.
- Clean our hands often.

We ask you or a loved one to:

- Ask questions.
- Speak up if you are concerned about a test, procedure or medicine.
- Check the information on your ID bracelet for accuracy, including current medications.
- Please wear your ID bracelet throughout your stay.
- Clean your hands often and remind visitors to do the same.
- Remind us if we do not carry out our pledge to you.

Your Health Care Team

While you receive treatment, you are likely to have a team of health care professionals involved in your care. This well-rounded team enhances your care.

The members include:

- Attending Physician – doctor that supervises your treatment
- Residents/Interns/Fellows – doctors specializing in a selected field of medicine who create your treatment plan
- Nurse Practitioners/Physician Assistants – licensed professionals who work closely with the attending physician in planning your care
- Registered Nurses – nurses will plan and evaluate your daily care, administer medications and treatments, and provide education for discharge
- Pharmacists – a pharmacist will review your medication orders and work with your doctor and nurse to ensure safe and accurate medication therapy
- Others who may be involved in your care:**
 - Clinical Dietitians
 - Nursing Support Staff
 - Social Workers/Care Managers
 - Rehabilitation Specialists (Physical Therapists, Occupational Therapists and Speech Language Pathologists)
 - Chaplain/Spiritual Care
 - Nursing/Medical Students
 - Your caregiver

Preventing Falls

In the hospital, people can be at a higher risk for falls. Illness, surgery and medicines can weaken or affect your balance and judgment. Also, medical equipment and the unfamiliar environment can make movement more difficult. We are committed to keeping you safe from injury during your stay.

During your stay we will:

- Assess you for your risk of falling upon admission and as your condition changes.
- Determine what preventive measures should be taken to try to prevent a fall while you are in the hospital, and share this information with other staff involved in your care.
- Show you how to use your call bell and remind you when to call for help.
- Respond to your calls for assistance in a timely manner.
- Assist you with getting in and out of bed and using the restroom as needed.
- Visit you (round) every hour to check on you.

Preventing Infections

You Are Part of the Health Care Team

Clean your hands and remind others to clean their hands. Either use hand gel or wash your hands after using the bathroom, before eating, or after touching something that is soiled.

The health care team is required to wash or sanitize their hands before entering and after leaving your room. They should wear gloves when they perform tasks, such as drawing blood or touching wounds or body fluids. Staff will welcome your reminder to clean their hands or wear gloves.

Preventing spread of respiratory infections

Cover your mouth and nose when sneezing or coughing by using tissues or the bend of your elbow. Both tissues and masks are available upon request. Please use these if you have a runny nose, sneeze or cough. Please remember to wash your hands, especially after you sneeze, cough or use a tissue.

Visitors

If your visitors are sick, you should ask them not to visit.

Vaccinations

When you are admitted to the hospital, you may be asked about your desire to have a flu or pneumococcal vaccination. They are very effective at reducing the spread of disease.

Additional Preventive Measures

There are some bacteria that require special measures to prevent the spread of infection—Methicillin Resistant *Staphylococcus Aureus* (MRSA), Vancomycin Resistant *Enterococci* (VRE) or *Clostridium Difficile* 9 (C-diff). These infections can be spread by contact with clothing, hands, personal items or health care equipment. If you have one of these conditions you will be placed in "isolation" to prevent the spread of infection to others. A sign will be posted on the room door and both staff and visitors will be required to wear protective gowns and gloves, and in some cases, a mask. Hand hygiene is very important in preventing the spread of these conditions. If you are in isolation, speak to your care provider before leaving your room.

Keeping You Safe

There are steps the hospital takes to keep you safe. As a patient, you can make your care safer by being an active, involved and informed member of your health care team.

- Provide you with safe footwear and any recommended equipment (such as a walker or bedside commode) that will make it safer for you to move about.
- Make sure the items you need are within reach before staff leaves your room.

We ask you or a loved one to:

- Tell the nurse if you have a history of falls.
- Ask your nurse about your assessed risk for falling and what prevention measures are being taken to reduce that risk.
- Use the call bell before attempting to get out of bed and wait for staff to come and help you.
- Wear non-skid footwear and use equipment that has been provided for your safety.
- Call your nurse if you feel dizzy or lightheaded.
- Use your glasses, walker or cane.
- Sit on the side of the bed for a few minutes before getting up.
- Use caution when walking around with wires, oxygen or other tubing.

You can prevent falls at home by:

- Getting your vision checked regularly.
- Wearing your glasses or contacts.
- Using walking aids, such as a cane or walker.
- Checking your home for hazards, including clutter, loose carpets, poor lighting and extension cords.
- Using non-slip carpets.
- Installing a grab bar in your shower or tub, and if necessary, using a shower seat.
- Telling your doctor if you feel dizzy, "off balance," or have trouble walking.
- Wearing sturdy shoes or slippers that fit well and have a non-skid sole and keeping your shoes laced and tied.
- Keeping an up-to-date record of your medications, both prescription and over-the-counter.
- Staying as active as you can and participating in an exercise program.

Questions to ask your health care team:

- What pain medicine is being ordered or given to me?
- Can you explain the doses and times that I should take this medicine?
- How often will I need to take the pain medicine?
- How long will I need to take the pain medicine?
- Can I take the pain medicine with food?
- Can I take the pain medicine with other medicines?
- Should I avoid drinking alcohol while taking the pain medicine?
- Are there any side effects of the pain medicine?
- What should I do if the medicine makes me sick to my stomach?
- What can I do if the pain medicine doesn't work?
- What else can I do to treat my pain?

Only you know how much pain you feel. Your pain can be measured. You will be asked to rate your pain using a scale like one of these. Choose a number from 0-10 that best describes your pain, with 10 being the worst.



Remember: Your health care team will not know how much pain you have unless you tell them. The key to successful pain management is communication.

Medication Safety

While you are in the hospital, it is important to talk to your health care team about your medicines. Bring a list of medications you take at home, including:

Prescription medicines

Over-the-counter medicines (like aspirin and rough medicine)

Vitamins

Herbal products

Diet supplements

Natural remedies

Amount of alcohol you drink each week

Recreational drugs

Understanding and Treating Your Pain

There are many different causes and kinds of pain. Treating pain is the responsibility of your doctor, nurse and other members of your health care team. You can help them by asking questions and finding out more about how to relieve your pain.

Managing your pain:

- Most pain can be controlled.
- Communication with your health care team about your pain is important.
- You and your health care team can work together to manage your pain.

Questions your health care team will ask you about your pain:

- "Where do you feel pain?"
- "How long have you had the pain?"
- "How does the pain feel: is it dull, tender, aching, cramping, shooting, burning, radiating, throbbing, stabbing, tingling, gnawing, squeezing?"
- "What makes the pain worse? What makes the pain better?"

- Make sure your ID bracelet is visible and accurate.

Let your health care team know if you have allergies to foods or drugs or have ever had a bad reaction to any drug, food or latex product.

- Ask your health care team about your medicines – what they are, what they look like, what they do, at what time they are given and what side effects you should expect or report.

- Look at all medicines before you take them. If you do not recognize a medicine, let your nurse know.

- Do not take medicines that you brought to the hospital from home unless your health care team tells you it is okay. You should give your personal supply of medications to your nurse until you leave the hospital or give them to someone to take home for you.

Nutrition

Your nutrition care and recovery are very important to us. Your physician and a registered dietician evaluate your medical status and prescribe a diet appropriate for your medical condition. This is why we ask that family members not bring you food from home.

If for religious or cultural reasons, you are unable to select from your menu, please advise your nutrition representative so we may accommodate your needs. If you have questions about your meal service, please call 410-550-0635 between 5 a.m. and 7:30 p.m., or if you have questions about special dietary concerns, you can reach a nutrition services representative by calling 410-550-1549. Meal delivery times vary by patient unit. The staff on your unit will know what the delivery times are for that particular unit. We request that you eat in your room, unless you have the written consent of your physician. If possible, please assist us by clearing your over-bed table at meal times. Please notify the nursing staff and/or patient advocate in advance if you wish to purchase a meal tray for a guest.

Room Service

Admitted patients may have access to a menu with more selection and customization, including build-your-own sandwiches and made-to-order omelets and pizzas. Room service is available from 6:30 a.m. to 6:30 p.m., each day.

No Smoking

To protect the health of our patients, visitors and staff, smoking is prohibited (including the use of electronic cigarettes) in all areas of the hospital and is limited to the assigned smoking areas on the campus. If you are interested in smoking cessation, ask your health care provider about resources or call 1-800-QUIT-NOW to be connected to the quit line in your state.

Studies suggest that everyone can quit smoking. Your situation or condition can give you a special reason to quit.

- Pregnant women/new mothers: By quitting, you protect your baby's health and your own.
- Hospitalized patients: By quitting, you reduce health problems and help healing.
- Heart attack patients: By quitting, you reduce your chance of a second heart attack.
- Lung, head and neck cancer patients: By quitting, you reduce your chance of a second cancer.
- Parents of children and adolescents: By quitting, you protect your children and adolescents from illnesses caused by second-hand smoke.

YOUR EXPERIENCE

Advance Directives

Advance directives are documents you create to describe the extent of medical treatment you do or do not want to receive if you are unable to communicate your wishes. You have the right to make an advance directive, such as a living will or durable power of attorney for health care, and to appoint someone to make health care decisions for you if you are unable. Upon your admission, your health care team will ask you if you have an advance directive. We recommend that you discuss advance directives with your family members, doctors, nurses and clergy while you are alert and feeling well. Bring any advance directives you may already have to the hospital with you.

For information about advance directives or to obtain the necessary forms, call Patient Support at 410-550-0627.

Medical Orders for Life-Sustaining Treatment (MOLST)

A physician, physician assistant or nurse practitioner may ask you about a Medical Order for Life-Sustaining Treatment form, or MOLST. This form gives you options for cardiopulmonary resuscitation and other life-sustaining treatments that 911 emergency services will follow, as well as any Maryland hospital or health care facility. The medical orders may instruct 911 responders to provide comfort care instead of resuscitation if that is your wish. Be sure to keep extra copies available. You can find more information at <http://marylandmolst.org/pages/consumers.htm>.

If you have any questions about MOLST, please ask your health care team.

Admitting and Registration

The registration process is in place to update current information and correct changes. By checking your address, birth date and other information, we are making sure that your medical record and bills are handled smoothly and accurately.

Room Assignment

Upon admission, the nursing staff will show you the features of your room, including your bed controls and the nurse-call system.

Cashier's Office

The cashier's office, located on the main level of the Francis Scott Key Pavilion, provides a safe to secure your personal valuables, if needed, and accepts payments for your hospital bills. The office is open Monday through Friday from 8 a.m. to 4 p.m.

Mail Delivery

Mail is picked up from the mailroom once daily. The nursing staff will bring your mail to your room. Stamped outgoing mail may be left with the nursing unit secretary for mailing. Mail collection boxes are located at the entrances to the Pavilion (red awnings) and the John R. Burton Pavilion.

Telephone

There will be a daily charge for use of the telephone with a one-time activation fee. The daily charge for this service can be billed to your home phone number. Your service will end upon discharge. To stop service at any time during your stay or for more information about charges or billing, please call 1-800-775-8352.

Television

We are pleased to offer free TV service during your stay.

This includes access to:

- Your favorite TV channels.
- On-demand patient education videos. Choose from a wide range of topics to learn about your illness, treatment or ways to stay healthy.
- The Care Channel and In Room Symphony. Tune in to these stations for pretty scenery and soothing music.

Cell Phones

The use of cell phones is prohibited where critical medical equipment is in operation. Please read and follow all posted signs about the use of cell phones, and use only in approved areas.

If you must use your cell phone, please speak in a low voice so as not to disturb the privacy and comfort of other patients and visitors.

Personal Items and Valuables

You are encouraged to bring only essential items to the hospital such as sleepwear and toiletries. Large sums of money, keys, jewelry, personal papers and other valuables should be left at home. For safety reasons, do not bring radios, hair dryers, fans, heaters or other electric devices. Personal equipment with two-pronged plugs is not permitted. The hospital is not responsible for lost or stolen items, such as laptops, portable music players, cell phones, money or jewelry.

To keep your personal items secure you should:

- Keep eyeglasses and hearing aids in a case in the top drawer of your bedside table when you are not using them.
- Keep dentures in a denture cup in the top drawer of your bedside table. Do not place dentures on your food tray, in a disposable cup, on the bed linen or in a tissue.
- Place clothing in your room closet, bedside table or suitcase.

Guide Dogs and Other Service Animals

Service animals are those animals trained to help patients and visitors with activities of daily living. They are welcome in any area of the hospital that is unrestricted to patients and visitors, provided that the presence of the service animal does not alter the policies, practices or procedures of Johns Hopkins Bayview Medical Center. For information, call the Office of Patient Experience at 410-550-0626.



We acknowledge the positive impact that visitation has on the healing process. The Medical Center supports open visitation according to the preferences of the patients we serve.

Visitation is a right that is given fully and equally to those visitors chosen by the patient (or his/her representative) regardless of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.

Visitors may be restricted at the discretion of the Medical Center if the comfort or safety of any patient, staff or other visitor is determined to be at risk or if the operation of the facility will be impeded significantly as a result of the visitation (i.e., interferes with a patient care team's ability to practice safely, disrupts the delivery of patient care or creates a hostile or intimidating environment). The Medical Center also reserves the right to request visitor identification.

For your child's health and the comfort of our patients, we request children under 12 not visit. Children without authorization to visit will remain at the entrance waiting area and must be supervised by an adult at all times.

It is expected that visitors will:

- Not visit if they are sick.
- Maintain a quiet environment and avoid unnecessary noise.
- Wash with hand gel before entering the room and exiting the room.
- Comply with any infection control practices that may be important to the patient's condition (e.g., wear isolation gown, mask and/or gloves).
- Comply with safety and security procedures.
- Act in a respectful manner.
- Wear and display visitor wristbands at all times while on hospital property.
- Not take photographs or videos without prior patient and hospital authorization.
- Dress appropriately—shirt and shoes must be worn while in the Medical Center.

In response to a visitor who has displayed unacceptable behaviors of any kind, security measures including visitor restriction and or legal action will be taken. Unacceptable behaviors include but are not limited to:

- Unreasonable interference with a patient's plan of care.
- Harassment of any kind, including inappropriate telephone calls to a staff member.
- Use of loud, threatening, abusive or obscene language.

- Offensive remarks of a racial or sexual nature.

- Use of physical violence or acting in a threatening manner toward staff.

- Coming on hospital property under the influence of drugs or alcohol.

- Damage of hospital property.

- Theft.

- Possession of weapons or firearms.

- Retaliation against any person who addresses or reports unacceptable behavior.

- Excessive noise that is distracting to others in the vicinity.

Parking

Parking is available in the Medical Center parking garage and visitor parking lots at a reasonable hourly and daily rate. A number of spaces are available for people with disability. If you visit the Medical Center often, ask at the parking garage office (located in the garage) about purchasing a coupon book at a discounted rate. For more information about parking, call 410-550-0168.

Food and Snacks

Bayview Cafe

Visitors are welcome to dine in the Bayview Cafe, located on the main level of the Pavilion near the Red Awning.

The daily hours are:

Breakfast	6:30 to 9:30 a.m.
Lunch	11:30 a.m. to 2 p.m.
Snack	2:30 to 4:30 p.m.
Dinner	4:30 to 7 p.m.

Vending Machines

For your convenience, vending machines are adjacent to the Bayview Cafe.

Other Food and Snack Retail Outlets

- 301 Building Lobby, 7 a.m. to 4 p.m.
- Alpha Commons Building Lobby, 7 a.m. to 4 p.m.
- Bayview Medical Office Building, located by the Blue Awning, 7 a.m. to 2 p.m.

Safety and Security

Security staff are available at all times to provide escort to any location on the campus, assist with car trouble and provide information on lost and found items. Call 410-550-0333 for assistance.

Fire Drill

For your protection, the hospital regularly conducts fire and disaster drills. These drills are announced over the speaker system. If a drill occurs while you are here, please remain in your room and do not be alarmed. The staff is trained to ensure safety.

Flowers and Mail

Flowers and cards may be sent to you in your room.* Your mailing address while you are in the hospital is:

Your Name
Room Number
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore, MD 21224-2780

*Live plants, flowers and fruit baskets are not permitted in the intensive care areas or the Johns Hopkins Burn Center.

Gift Shop

The gift shop is located in the Francis Scott Key Pavilion. A variety of snacks, drinks, gifts, toys, cards and toiletries are available. We offer convenient day and evening hours. Call 410-550-0266 for more information.

JHGuestnet

JHGuestnet allows you to access the wireless network during your visit as a valued guest. We are pleased to provide this service to you.

Requirements - A notebook computer running a Windows or Macintosh operating system with a wireless interface card is required to access JHGuestnet. Your computer should be running a commercial anti-virus product.

Connecting - Open your wireless network configuration page, and select the JHGuestnet network.

You may receive notification that information sent over the network is not encrypted. Select "connect anyway" in order to proceed. Once connected, please read and accept the terms and conditions of use. Your default home page will not be displayed.

NOTE:

JHGuestnet is not available in all areas of the Medical Center. Some websites may be blocked, however, access to corporate and personal email accounts should function properly. If you feel a website was blocked in error, contact the Johns Hopkins Support Center at 410-955-1111.

PATIENT- AND FAMILY-CENTERED CARE

Office of Patient Experience

Quality health care is our goal for every patient. Your care team is specially trained to take care of your needs. In some cases, you may want to talk with a patient representative about a special concern or to recognize our faculty or staff. Patient representatives can help and, if necessary, act as your direct contact with administration.

For assistance, call 410-550-0626 or the operator at 410-550-0100.

Spiritual Care and Chaplaincy

Spiritual Care and Chaplaincy is available to patients and families of all faith traditions. Our chaplains provide spiritual and emotional support and comfort to patients and their loved ones during their hospital experience. Chaplains may provide religious and sacramental services, listening and support, as well as assistance with faith-specific needs, such as prayer or advice about a spiritual practice. Chaplains are available 24/7 and can be reached by asking your nurse or calling the operator at 410-550-0100. You also may want to call your own clergy or spiritual support person to let them know you are in the hospital. The meditation chapel, located on the main floor of the Medical Center, is available to patients and families of all beliefs. A prayer book is available in the chapel for writing down specific prayers. These prayers are collected and each one is prayed aloud at the beginning of the day by the chaplains. Spiritual Care and Chaplaincy can be reached by calling 410-550-7569.

Community Health Library

We invite our patients, families, friends and neighbors to visit our Community Health Library. Located on the main floor of the Francis Scott Key Pavilion, it offers a variety of information on health and wellness issues. The library provides access to reliable medical resources through print and online resources. There is a library staff member available to assist you with all of your research needs. The library is open from 9 a.m. to noon and 1 to 4 p.m. on weekdays. Please call 410-550-0681 for more information.

Ethics Committee

The Ethics Committee is committed to serving the needs of the Medical Center with respect to ethical concerns that may arise in the course of patient care. The Ethics Committee provides an ethics consultation service for patients, family members and staff faced with difficult treatment decisions. The committee includes physicians, nurses, administrators, social workers, clergy and community representatives. To request a consult, call Patient Support at 410-550-7097, Monday through Friday, 8:30 a.m. to 5 p.m. After hours and on weekends, call the paging operator at 410-550-0100.

Interpreters

Foreign language interpreters are available. For Spanish and Greek interpreters, your health care team can assist you, or you can call Patient Support at 410-550-0627.

For telephonic interpretation, the CyraCom foreign language phones are available on every patient unit. Your nurse can assist you.

For sign language interpreters or to arrange for a TTY (text telephoned), your nurse can assist you, or you can call Patient Support at 410-550-0627.

Labyrinth

The labyrinth provides community members, patients, visitors and employees with a peaceful, meditative and healing space. This spiral walking course, which leads into the center and back out, helps people find physical and mental relaxation. The labyrinth is located on Mason Lord Drive.

Organ and Tissue Donation

Organ and tissue donations provide new hope to seriously ill or injured persons. We participate with The Living Legacy Foundation to manage organ and tissue donations. If you already have a donor card, it is important that your family is fully informed of your wishes. We comply with state and federal laws and offer the option of organ and tissue donation to all families when it is appropriate. Please ask the Medical Center staff for information about your option to donate or call the Living Legacy Foundation of Maryland at 1-800-641-HERO (4376).

Palliative Care

The Palliative Care team helps patients and families dealing with serious illnesses. The team addresses physical, psychological, social and spiritual needs and can help patients cope with the pain and anxiety that comes with serious health problems.

The team consists of a physician, nurse practitioner, social worker and chaplain who can visit you in your hospital room. Any person with a serious or chronic illness, or who is suffering from uncomfortable symptoms, or who has family members who are experiencing stress related to their loved one being in the hospital, could benefit from a visit from the Palliative Care team. If you would like someone from the Palliative Care team to meet with you, ask your doctor to make the referral.

Patient and Family Advisory Council

Your health care experience can help improve the health of our communities. We are looking for patients and families who are willing to share their experience and become a vital part of our Patient and Family Advisory Council (PFAC).

Your participation can:

- Promote improved relationships between families and hospital staff.
- Shape change throughout the Medical Center and improve patient safety.
- Provide a venue for patients and families to assist in providing input on the delivery of services to patients.
- Give others the chance to hear the voice of the patient.

To learn more, or to apply as a PFAC volunteer, please call 410-550-0627.

Volunteers

We have many volunteers who donate their time and talent to enhance your stay. Volunteers are available in departments throughout the Medical Center. Many of them enjoy visiting at the bedside, talking with patients, and performing clerical and other services. If you would like more information, please call Volunteer Services at 410-550-0627.

Your Experience

After you return home, you may receive a survey in the mail asking you to tell us about your experiences at. Your feedback is very important to us, so please take the time to complete the survey.

MEDICAL RECORDS/ BILLS AND INSURANCE

MyChart

Your medical records are available in your online MyChart account at no charge. MyChart is a secure website that lets you access important information from your hospital record. It includes most test results, diagnosis and medications. When you leave the hospital, the last page of your After Visit Summary (AVS) has an activation code and other information to help you set up your account. If your personal physician is affiliated with Johns Hopkins Medicine, you may have already set up your account. For more information, view our Frequently Asked Questions at mychart.hopkinsmedicine.org.

Medical Records

You have the right to obtain a copy of your medical records and to request that your records be provided to someone else (subject to certain limitations). In order to protect your privacy, we must have your written permission before releasing the records. You can contact Health Information Management Monday through Friday, 8:30 a.m. to 5 p.m., at 410-550-0688, or email the department at libmchime@jhmi.edu.

When completing the health record release form:

- Be sure to fill it out completely, including signing and dating it.
- No information can be released unless the form is properly signed and dated. Incomplete forms may be returned to you for completion.
- If you are the health care agent or court appointed representative, please bring proof of your authority to act on behalf of the patient.

Return the completed form (and any attachments) via fax, in person or by mail:

Fax # 410-550-3409

Mailing address:

Johns Hopkins Bayview Medical Center,
4940 Eastern Avenue, Baltimore, MD, 21224
Attention: Health Information Management

5 About Your Bill

Maryland's Health Services Cost Review Commission sets and approves rates and charges for Johns Hopkins Bayview Medical Center. The commission's purpose is to protect patients from unjust and unfair costs and control hospitals' charges.

Before admission, all non-emergency patients will be asked for evidence of adequate hospital and medical insurance. Many insurance carriers require us to contact them for approval before admission.

A representative from the pre-billing office will contact you for financial information and explain our policies. Please have all of your insurance information available (insurance company's name, contract number, group number). As a convenience to you, we will bill your insurance company.

If you do not have health insurance, have difficulty paying your bill, believe you are entitled to Medical Assistance or if you have questions about your account before or during your stay, contact your Certified Application Counselor/Financial Counselor at 410-550-0830 or 410-550-3505. Unless arrangements have been made, payment in full for service is due on receipt of your final bill. We accept MasterCard, VISA, Discover and American Express. Insurance carriers, Medicare and Medicaid require separate billing for professional fees from physicians and hospital charges. The bills are outlined in the section that follow.

Your Johns Hopkins Bayview Medical Center Bill

Your Medical Center bill includes room and associated charges, X-rays, laboratory work, medicines and other medical supplies. If you have both inpatient (overnight stays) and outpatient (same-day or office visit) services, these may be billed separately.

Your Doctor's Bill

Your doctor's bill includes fees for examinations, care and interpretation of diagnostic tests. You may receive several bills if more than one physician is involved in your care. Bills should be paid according to arrangements made during the admission process.

Physician charges are not included in hospital bills and are billed separately.

6 Patient Billing and Financial Assistance Information

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought into the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, you may qualify for free or reduced-cost medically necessary care if you:

- Are a U.S. citizen or permanent resident living in the U.S. for a minimum of one year.
- Have no other insurance options.
- Have been denied medical assistance or fail to meet all eligibility requirements.
- Meet specific financial criteria.

If you do not qualify for Maryland Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill. You can call 443-997-0200 or 1-877-361-8702 with questions concerning:

- Your hospital bill.
- Your rights and obligations with regard to your hospital bill.
- How to apply for free and reduced cost care.
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills.

For more information about Maryland Medical Assistance, contact your local department of social services at 1-800-332-6347, TTY 1-800-925-4434 or visit www.dhs.state.md.us.

If you need health insurance, you can contact the Maryland Health Connection at 1-855-642-8572, TTY 1-855-642-8573 or marylandhealthconnection.gov.

7 Health Information Exchange

As permitted by law, we may share information that we obtain or create about you with other health care providers through the Chesapeake Regional Information System for our Patients, Inc. (CRISP). Maryland's internet-based health information exchange (HIE), IHE, is a way of instantly sharing health information among doctors' offices, hospitals, labs and radiology centers, and will assist your doctors in making decisions about your care.

You may choose to "opt out" of CRISP. "Opting out" means that doctors will be unable to access your health information through the CRISP HIE. However, opting out of the HIE will not prevent your doctor from being able to use the HIE to view the results of tests ordered by your doctor. You may "opt out" by contacting CRISP at www.crisphie.org or calling 1-877-952-7477. You may change your decision at any time by contacting CRISP.

GOING HOME

Discharge

Once your doctor has completed your discharge forms, you may leave the Medical Center. You may want to make arrangements with a family member or friend to help you when it is time to go home. If you arrange for someone to take you home, there are several 30-minute parking spaces available for your driver at the main entrance. Please take an extra minute to ensure you have all of your belongings.

Discharge Instructions

Before you leave, your nurse provides instructions, prescriptions and return appointment slips. Please make certain you ask questions if you do not understand your discharge plan or prescribed medication.

Pharmacy

Discharged patients, as well as those who visit the clinics on a follow-up basis, may have their prescriptions filled at our outpatient pharmacy.

As part of our effort to ensure comprehensive and consistent care, we offer patients a full-service pharmacy located in the Bayview Medical Offices. The pharmacy can fill your prescription(s) and over-the-counter medication needs.

Hours are Monday through Friday, 8 a.m. to 7 p.m., Saturday 10 a.m. to 4 p.m. and Sunday 10 a.m. to 2 p.m. Most prescriptions can be filled while you wait.

The pharmacy can provide a consultation to patients and their physicians regarding patient education, drug information and medication administration aids. The pharmacy can also help you obtain home-based infusion therapy, medical equipment and respiratory equipment. For the pharmacy at the Medical Center, call 410-550-0961 or FAX 410-550-5566. The main referral line for home care pharmaceutical needs is 410-288-8100.

8 Safe Practices

As a partner in your health care, continue safe practices at home:

- Assign a Health Buddy.
- Talk with your doctors and pharmacist. Ask questions and write down what they say.
- Obtain bedside rails at home if you need them.
- Keep a phone or bell near your bed so you can alert someone when you need help.
- Never smoke in bed.
- Maintain safe practices at home if you have oxygen equipment. Oxygen is highly flammable.
- Use a grounded or three-prong connector for medical equipment. Do not use extension cords.

9 Called to Care

Called to Care is a program that prepares and supports individuals caring for loved ones with health-related needs or limitations. The program, which is funded in part by the Weinberg Foundation, offers assistance in several ways: supportive services, education, and partnerships with community organizations and agencies. For more information, call 410-550-8018.

10 Bridge to Home and Health Buddy Program

Being discharged from the hospital or seeing your health care provider can be overwhelming. Identifying a friend or family member to provide extra support when you leave the hospital or visit your health care provider can help you manage your health care in a variety of ways. Here are a few examples of how your Health Buddy can help you: by being present at the hospital when discharge instructions are reviewed, scheduling health care appointments, getting your prescriptions filled and helping to organize your medications. Your Health Buddy will be your partner in health. For additional information, please talk to your health care provider.



Johns Hopkins Bayview
Medical Center

4940 Eastern Avenue
Baltimore, MD 21224-2780



EXHIBIT 7

HOW CAN I PAY?

Paying your Johns Hopkins bill is about to get easier. You may pay your bill anytime 24/7 online, by mail or by phone.

To pay easily and securely online, view your test results, access your health record, make appointments, and enroll in electronic statements, sign up for MyChart at:

<https://mychart.hopkinsmedicine.org>

All Johns Hopkins Medicine healthcare provider locations accept MasterCard, Visa, American Express and Discover credit cards. To pay by phone please call **1(855)-662-3017** and select **Option 1**. You can also pay by mail using the coupon at the bottom of your statement.

INTERNATIONAL AND SPECIAL SERVICES

International patients and their physicians or representatives should contact Johns Hopkins Medicine International at +1-410-955-8032 to schedule medical appointments, coordinate admitting and registration, and get assistance with language interpretation, transportation and airport pickup, lodging and consolidated billing.

Patient coordinators and interpreters fluent in more than 25 languages are on site to assist patients in all aspects of care 24 hours a day.

International patients are those who are not citizens of the United States even if they speak English and do not require interpretation. If you are uncertain about whether you qualify as an international patient at Johns Hopkins Hospital or Bayview Medical Center, please contact International Finance at +1-410-955-5939.

WHY CAN'T MY SPOUSE GET INFORMATION ABOUT MY BILL?

Medical information is confidential, so we are not able to discuss your bill with anyone else but you. (*There are some exceptions such as cases involving patients who are minors or have legal guardians.*) You can authorize us to discuss your bill with someone else by filling out a HIPAA compliant authorization. Contact us for a HIPAA form to complete and return.

INTERPRETING SERVICES

Foreign Language Interpreting
+1-410-614-INTL (4685)

Sign Language Interpreting

Deaf and hearing-impaired patients can arrange for sign language interpreters or the use of a TTY by calling the following numbers:

410-955-2273 (*The Johns Hopkins Hospital*)
410-550-0626 (*Johns Hopkins Bayview Medical Center*)
410-740-7770 (*Howard County General Hospital*)
301-896-3100 (*Suburban Hospital*)
202-537-4070 (*Sibley Memorial Hospital*)

To contact other Hopkins Medicine care providers, please call Maryland Relay 7-1-1:
1-800-735-2258.

I HAVE A QUESTION ABOUT MY BILL, WHOM DO I CALL?

If you have questions about any bill you receive from Johns Hopkins Medicine, please contact us at the appropriate number listed below.

The Johns Hopkins Hospital

Johns Hopkins Bayview Medical Center

Howard County General Hospital

Suburban Hospital

Sibley Memorial Hospital

Office of Johns Hopkins Physicians

443-997-3370 (*local*)

1-855-662-3017 (*toll free*)

Monday – Friday 8:30 am – 4:30 pm EST

pfscs@jhmi.edu

Johns Hopkins Bayview Care Center

443-997-0229

Johns Hopkins Home Care Group

410-288-8000

1-800-288-2838 (*toll free*)

On the Web

For more information, go to
www.hopkinsmedicine.org

Understanding your medical bills

A guide to paying your
Johns Hopkins Medicine bills





This guide will help you understand your financial responsibility and the complex process involved in paying medical bills. Take time to read this brochure carefully. Keep it with your other financial or health records. It will be a handy resource when questions arise.

WHAT DO I NEED BEFORE MY APPOINTMENT?

For each visit, remember to bring the following:

1. Health insurance card.
2. Picture identification.
3. Referral and/or authorization forms.

Please become familiar with your insurance plan(s) before your appointment. If you are unsure what service is covered, contact your insurance company's member services office directly.

In order to provide you with the most complete and accurate billing services, be sure to arrive early for your appointment.

- For clinic or outpatient visits, arrive 15 to 30 minutes before your appointment to allow for registration.
- For inpatient procedures, arrive by the specific time requested by our admitting staff or your physician's office.

Your Bill: There are many different types of bills depending on the location of the services you received and the billing cycle, as a result you may receive more than one bill, but you will not be billed more than once for the same service.

JOHNS HOPKINS IS SIMPLIFYING OUR BILLING STATEMENT!

For services after July 23, 2018, you will receive **one bill** for your care at Johns Hopkins Health System.

However, you may still receive multiple bills for services received prior to July 23, 2018, until those balances are paid from hospital-based physicians like anesthesiologists, pathologists, as well as from private community physicians.

We are also consolidating our call centers so that you have one place to call for questions about your bills. Our Customer Service department can be reached at 1-855-662-3017 and select 0.

This new bill was designed with you in mind to help you better understand your financial responsibility.

Inpatient Hospital Bill

Patients admitted to the hospital (inpatients), will receive multiple bills. A hospital bill will include charges for your room, food, medical supplies & services, and any tests or procedures that you undergo, including X-rays.

Outpatient Hospital Bill

Patients seen in a clinic or outpatient setting may receive multiple bills. Your clinic or outpatient bill will include charges for the use of the hospital facility and any tests or procedures done at the time of your appointment. For scheduling reasons, some tests may be performed later and will be billed separately.

Home Care Bill

Home care patients will receive a bill for services and/or products provided in the home. This bill may include charges for a visit from a nurse, home health and/or include items like IV therapy and home medical equipment.



WHEN SHOULD I PAY?

Before your admission, appointment or procedure please provide your insurance information. You may be required to pay for part of the service not covered by insurance. It is our policy to collect all amounts owed before services are rendered. For non-emergency visits or admissions, your treatment may be denied or delayed if your financial obligation is not met before the service date.

WHY DID I GET ANOTHER BILL?

Depending on your insurance benefits, the amount collected at your visit may be based on *estimated* charges. Fees associated with admission and outpatient surgeries are estimates based on previous services provided by Johns Hopkins Medicine healthcare providers. Your admission or procedure may require more or less services than initially estimated.

As a rule, you should contact your insurance payer before any hospital, clinic or physician office visit to find out what is and is not covered under your plan and whether you will be responsible for any part of the payment. Some insurance companies require a Co-pay for both hospital charges and physicians fees.

HOW CAN I GET FINANCIAL ASSISTANCE?

If you are unable to pay for your necessary medical care, you may qualify for financial assistance. If you need assistance, or would like additional information, please contact any of the billing offices listed on the back of this brochure. Financial Assistance will be based on the following factors:

- U.S. citizen or in the U.S. legally.
- Have exhausted all insurance options.
- Have been denied Medical Assistance.
- Other criteria regarding income, assets and outstanding debt.

EXHIBIT 8

Financial Assistance Policy

If unable to pay for medical care, you may qualify for financial assistance if you:

- Exhausted all insurance options
- Were denied medical assistance through all other available means
- Meet other criteria for financial assistance

For help, more information or to apply for financial assistance, please call

443-997-0200 or 1-877-361-8702

Or visit

hopkinsmedicine.org/home/patient_assistance

If you feel you have been improperly denied free or reduced charged care, call the Compliance Office.

1-877-WI-COMPLY
(1-877-932-6673)

Si usted es incapaz de pagar por sus servicios médicos, se puede calificar para asistencia financiera:

- Si ha agotado todas las opciones de los seguros
- Si le ha sido negado ayuda médica a través de todas las formas disponibles
- Si puede cumplir otro criterio para asistencia financiera

Si usted necesita ayuda o desea información adicional o un formato para aplicar para asistencia financiera, por favor comuníquese con

443-997-0200 or 1-877-361-8702

Or visit

hopkinsmedicine.org/home/patient_assistance

Si usted siente que le han sido negado los cargos gratuitos o los costos reducidos

llama Oficina de Conformidad

1-877-WI-COMPLY (1-877-932-6673)



EXHIBIT 9

JHHS Maryland Hospital Volumes: Inpatient Discharge, OP Visits
Volume by Fiscal Year

	Encounters by Fiscal Year		
	2016	2017	2018
Bayview Medical Center	418,127	413,876	407,981
Howard County General Hospital	137,157	130,000	117,274
Suburban Hospital	67,895	70,482	67,960
Johns Hopkins Hospital	890,750	848,770	843,816
Total JHHS Maryland Hospitals	1,513,929	1,463,128	1,437,031

	Debt Collection Lawsuits by CY		
	2016	2017	2018
Bayview Medical Center	487	237	395
Howard County General Hospital	489	319	411
Suburban Hospital	192	119	223
Johns Hopkins Hospital	535	338	428
Total JHHS Maryland Hospitals	1,703	1,013	1,457

	% Of Encounters Resulting in a Lawsuit		
	2016	2017	2018
Bayview Medical Center	0.12%	0.06%	0.10%
Howard County General Hospital	0.36%	0.25%	0.35%
Suburban Hospital	0.28%	0.17%	0.33%
Johns Hopkins Hospital	0.06%	0.04%	0.05%
Total JHHS Maryland Hospitals	0.11%	0.07%	0.10%

	Unique Patients by Fiscal Year		
	2016	2017	2018
Bayview Medical Center	118,198	121,975	120,549
Howard County General Hospital	83,923	81,793	77,445
Suburban Hospital	48,729	50,587	50,126
Johns Hopkins Hospital	271,442	271,418	267,562
Total JHHS Maryland Hospitals	522,292	525,773	515,682

	Debt Collection Lawsuits by CY		
	2016	2017	2018
Bayview Medical Center	487	237	395
Howard County General Hospital	489	319	411
Suburban Hospital	192	119	223
Johns Hopkins Hospital	535	338	428
Total JHHS Maryland Hospitals	1,703	1,013	1,457

	% Of Unique Patients Sued		
	2016	2017	2018
Bayview Medical Center	0.41%	0.19%	0.33%
Howard County General Hospital	0.58%	0.39%	0.53%
Suburban Hospital	0.39%	0.24%	0.44%
Johns Hopkins Hospital	0.20%	0.12%	0.16%
Total JHHS Maryland Hospitals	0.33%	0.19%	0.28%

EXHIBIT 10

Operating Margin by Hospital

Fiscal 2018

	FY2018 Total Revenue ^[1]	Hospital Regulated Operating Margin ^[2]	Hospital Total Operating Margin ^[2]	Total Margin Available to Contribute to Capital		
				Above 3%	Above 5%	Above 7%
210030 UM-SRH at Chestertown ^[3]	\$59,400,000	20.5%	13.9%	\$6,500,000	\$5,300,000	\$4,100,000
210049 UM-Upper Chesapeake ^[3]	343,200,000	16.3%	12.9%	34,000,000	27,200,000	20,300,000
210037 UM-SRH at Easton ^[3]	211,000,000	12.4%	10.9%	16,700,000	12,500,000	8,300,000
210035 UM-Charles Regional ^[3]	156,700,000	13.9%	10.4%	11,600,000	8,500,000	5,300,000
210010 UM-SRH at Dorchester ^[3]	51,100,000	11.4%	9.7%	3,400,000	2,400,000	1,400,000
210028 MedStar St. Mary's	196,800,000	15.9%	9.5%	12,700,000	8,800,000	4,800,000
210034 MedStar Harbor Hospital Cntr	194,500,000	16.0%	8.6%	10,800,000	6,900,000	3,000,000
210055 UM-Laurel Regional	103,000,000	17.0%	8.5%	5,700,000	3,600,000	1,600,000
210063 UM-St. Joseph Med Cntr ^[3]	414,400,000	13.8%	8.1%	21,000,000	12,700,000	4,400,000
210040 Northwest Hospital Cntr	266,900,000	18.5%	8.0%	13,400,000	8,100,000	2,800,000
210043 UM-BWMC ^[3]	428,100,000	8.4%	7.5%	19,300,000	10,700,000	2,100,000
210005 Frederick Memorial	355,800,000	17.4%	7.3%	15,200,000	8,100,000	1,000,000
210001 Meritus Medical Cntr	334,300,000	11.4%	6.6%	12,000,000	5,300,000	(1,400,000)
210033 Carroll Co Hospital Cntr	235,000,000	16.3%	5.9%	6,800,000	2,100,000	(2,600,000)
210015 MedStar Franklin Square	535,600,000	14.0%	5.8%	14,900,000	4,200,000	(6,500,000)
210057 Shady Grove	409,100,000	11.3%	5.8%	11,300,000	3,100,000	(5,100,000)
210056 MedStar Good Samaritan	275,800,000	12.4%	5.5%	6,800,000	1,300,000	(4,300,000)
210023 Anne Arundel Medical Cntr	633,000,000	10.5%	5.2%	14,000,000	1,400,000	(1,300,000)
Holy Cross (Germantown Incl)	611,400,000	11.1%	4.9%	11,500,000	(700,000)	(13,000,000)
210012 Sinal Hospital	783,500,000	12.7%	4.3%	10,400,000	(5,300,000)	(21,000,000)
210039 Calvert Health Med Cntr	150,000,000	11.9%	4.2%	1,800,000	(1,200,000)	(4,200,000)
210018 MedStar Montgomery	182,900,000	14.9%	4.1%	2,000,000	(1,700,000)	(5,300,000)
210008 Mercy Medical Cntr	539,000,000	6.2%	3.7%	4,000,000	(6,800,000)	(17,500,000)
210058 UM-ROI	124,900,000	4.2%	3.5%	700,000	(1,800,000)	(4,300,000)
210027 Western Maryland	332,200,000	12.6%	3.2%	700,000	(6,000,000)	(12,600,000)
210016 Washington Adventist	277,100,000	11.8%	3.2%	500,000	(5,000,000)	(10,600,000)
210011 St. Agnes Hospital	438,700,000	16.0%	3.0%	(100,000)	(8,900,000)	(17,700,000)
210048 Howard County General	313,000,000	6.9%	2.9%	(400,000)	(6,700,000)	(13,000,000)
210002 UMMC	1,478,500,000	4.3%	2.8%	(2,500,000)	(32,100,000)	(61,600,000)
210022 Suburban	329,400,000	7.3%	2.8%	(800,000)	(7,400,000)	(13,900,000)
210038 UMMC - Midtown	237,000,000	15.1%	2.6%	(900,000)	(5,600,000)	(10,300,000)
210006 UM-Harford Memorial	105,900,000	6.5%	2.1%	(1,000,000)	(3,100,000)	(5,200,000)
210024 MedStar Union Memorial	440,400,000	10.4%	1.8%	(5,500,000)	(14,300,000)	(23,100,000)
210051 Doctors Community	247,700,000	13.2%	1.6%	(3,400,000)	(8,300,000)	(13,300,000)
210019 Peninsula Regional	450,300,000	12.3%	1.6%	(6,400,000)	(15,400,000)	(24,400,000)
210060 FT. Washington	52,400,000	2.7%	1.1%	(1,000,000)	(2,000,000)	(3,100,000)
210009 Johns Hopkins	2,409,900,000	(0.2%)	0.5%	(61,200,000)	(109,400,000)	(157,600,000)
210003 UM-Prince George's Hospital	293,200,000	14.7%	(0.7%)	(10,800,000)	(16,700,000)	(22,600,000)
210029 JH Bayview	670,200,000	0.4%	(1.0%)	(27,100,000)	(40,500,000)	(53,900,000)
210044 GBMC	463,600,000	7.3%	(1.8%)	(22,400,000)	(31,700,000)	(41,000,000)
210013 Bon Secours	108,300,000	18.1%	(1.9%)	(5,300,000)	(7,400,000)	(9,600,000)
210061 Atlantic General	110,400,000	15.6%	(1.9%)	(5,400,000)	(7,600,000)	(9,800,000)
210062 MedStar Southern MD	264,200,000	5.6%	(4.3%)	(19,300,000)	(24,600,000)	(29,900,000)
210045 McCready Memorial	17,000,000	(12.0%)	(4.7%)	(1,300,000)	(1,600,000)	(2,000,000)
210017 Garrett Co Memorial	57,700,000	3.7%	(5.5%)	(4,900,000)	(6,100,000)	(7,200,000)
210032 Union Hospital of Cecil Co	166,200,000	6.3%	(8.4%)	(18,900,000)	(22,200,000)	(25,500,000)
Statewide	\$16,858,700,000	9.0%	3.4%	\$69,200,000	(\$268,000,000)	(\$605,200,000)

Notes:

[1] Source: HSCRC experience reports, FY2018

[2] Source: FY2018 RE schedules. December filers calculated using FY2017 RE

[3] UMMS total operating numbers may be distorted by the fact that UM Community Medical Group is reported as a non-hospital entity.

EXHIBIT 11

Table H: REVENUES & EXPENSES, INFLATED-ENTIRE FACILITY

	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
NET OPERATING REVENUE	\$ 605,677,000	\$ 610,284,000	\$ 628,477,000	\$ 643,825,000	\$ 658,806,000	\$ 674,333,000	\$ 690,467,000	\$ 706,125,000	\$ 725,171,000	\$ 774,753,000
Income from Operation	\$ 20,229,000	\$ 10,596,000	\$ 10,900,000	\$ 22,543,000	\$ 22,098,000	\$ 23,602,000	\$ 24,166,000	\$ 25,764,000	\$ 26,481,000	\$ 27,116,000
Project Depreciation and Amortization								17,309,000	17,621,000	17,621,000
Interest on Project Debt								13,000,000	12,728,000	12,442,000
Non-Operating Income	\$ (14,011,000)	\$ (7,320,000)	\$ (10,089,000)	\$ (16,296,000)	\$ (15,560,000)	\$ (11,310,000)	\$ 3,090,000	\$ 6,294,000	\$ 8,665,000	\$ 10,817,000
NET INCOME(LOSS)	\$ 6,218,000	\$ 3,276,000	\$ 811,000	\$ 6,238,000	\$ 17,498,000	\$ 22,291,000	\$ 27,197,000	\$ 31,998,000	\$ 35,096,000	\$ 37,933,000
Net Income without revenue from rate increase								\$ (1,302,000)	\$ 1,796,000	\$ 4,638,000
Net Income Ratio(Which Includes Non-Operating Income)	1.03%	0.54%	0.13%	0.97%	2.66%	3.31%	3.94%	4.35%	4.65%	4.90%
Operating Income Ratio	3.54%	1.74%	1.73%	3.50%	3.35%	3.50%	3.50%	3.50%	3.50%	3.50%
Operating Income Ratio without revenue from rate increases								-0.18%	0.24%	0.60%

EXHIBIT 12

Combined Quality and Safety Ratings - Maryland Hospitals

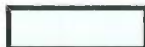
Hospital Name	Overall Star Rating	Patient Deaths*	Patient Safety**
Adventist HealthCare Shady Grove Medical Center	****	Average	Average
Adventist HealthCare Washington Adventist Hospital	***	Average	Average
Anne Arundel Medical Center	****	Below Average	Average
Atlantic General Hospital	***	Average	Average
Bon Secours Hospital	**	Average	Average
Calvert Memorial Hospital	****	Average	Average
Carroll Hospital Center	***	Average	Average
Doctors Community Hospital	***	Average	Average
Edward McCready Memorial Hospital	***	Average	Average
Fort Washington Medical Center	**	Average	Average
Frederick Memorial Hospital	****	Below Average	Average
Garrett Regional Medical Center	****	Average	Average
Greater Baltimore Medical Center	****	Better than Average	Average
Holy Cross Germantown Hospital	***	Average	Average
Holy Cross Hospital	**	Average	Average
Howard County General Hospital	***	Average	Average
Johns Hopkins Bayview Medical Center	***	Better than Average	Better than Average
Johns Hopkins Hospital	**	Average	Average
MedStar Franklin Square Medical Center	****	Average	Average
MedStar Good Samaritan Hospital	****	Average	Average
MedStar Harbor Hospital	***	Average	Average
MedStar Montgomery Medical Center	***	Average	Average
MedStar Southern Maryland Hospital Center	**	Average	Average
MedStar St. Mary's Hospital	***	Average	Average
MedStar Union Memorial Hospital	****	Average	Below Average
Mercy Medical Center	****	Average	Average
Meritus Medical Center	****	Average	Average
Northwest Hospital	***	Average	Average
Peninsula Regional Medical Center	****	Average	Better than Average
Sinai Hospital	***	Average	Average
St. Agnes Hospital	*	Average	Average
Suburban Hospital	****	Average	Average
Union Hospital of Cecil County	***	Average	Average
University of Maryland Baltimore Washington Medical Center	*	Below Average	Average
University of Maryland Charles Regional Medical Center	***	Average	Average
University of Maryland Harford Memorial Hospital	**	Average	Average
University of Maryland Laurel Regional Hospital	*	Average	Average
University of Maryland Medical Center	*	Below Average	Average
University of Maryland Medical Center Midtown Campus	**	Average	Average
University of Maryland Prince George's Hospital Center	*	Average	Average
University of Maryland Rehabilitation & Orthopaedic Institute	-	Average	Average
University of Maryland Shore Medical Center at Chestertown	**	Average	Average
University of Maryland Shore Medical Center at Dorchester	***	Average	Average
University of Maryland Shore Medical Center at Easton	***	Average	Average
University of Maryland St. Joseph Medical Center	****	Average	Better than Average
University of Maryland Upper Chesapeake Medical Center	***	Average	Average
Western Maryland Regional Medical Center	**	Average	Average



Below Average



Average



Above Average

Notes

Data Sources:

AHRQ-QI Composite Data (2015)

AHRQ-QI Provider Data (2015)

Hospital Compare Data (July 2018)

Accessed on MHCC website February 24, 2019

*Patients who died in the hospital after having one of six common conditions. Summary score that combines more than one rating related to the number of patients who die in the hospital into one score, includes deaths as a result of medical conditions and surgeries.

**How well this hospital keeps patients safe based on eleven patient safety problems. Summary score that combines more than one rating related to how the hospital keeps patients safe into one score.

EXHIBIT 13

Johns Hopkins Bayview Medical Center



4940 Eastern Avenue
Baltimore, MD 21224-2780



Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Dangerous object left in patient's body	0.074	0.382	0.021	0.000	MHCC	10/01/2015 - 06/30/2017
Air or gas bubble in the blood	0.000	0.045	0.001	0.000	MHCC	10/01/2015 - 06/30/2017
Patient falls	0.368	1.747	0.434	0.000	MHCC	10/01/2015 - 06/30/2017
Infection in the blood	0.334	2.935	0.789	0.000	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017
Infection in the urinary tract	0.282	3.163	0.874	0.000	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017
Surgical site infection after colon surgery	0.842	3.273	0.859	0.000	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017
MRSA Infection	2.326	3.383	0.881	0.000	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017
C. diff. Infection	1.040	1.988	0.793	0.000	2018 Leapfrog Hospital Survey	01/01/2017 - 12/31/2017
Dangerous bed sores	0.32	1.91	0.38	0.02	MHCC	10/01/2015 - 06/30/2017
Death from treatable serious complications	172.46	204.76	161.65	96.82	MHCC	10/01/2015 - 06/30/2017
Collapsed lung	0.37	0.47	0.29	0.11	MHCC	10/01/2015 - 06/30/2017
Serious breathing problem	6.65	17.91	8.23	1.71	MHCC	10/01/2015 - 06/30/2017
Dangerous blood clot	3.31	7.32	3.84	1.21	MHCC	10/01/2015 - 06/30/2017
Surgical wound splits open	0.53	1.90	0.85	0.32	MHCC	10/01/2015 -

06/30/2017

Accidental cuts and tears	0.87	2.15	1.29	0.57	MHCC	10/01/2015 - 06/30/2017
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Process measures include the management structures and procedures a hospital has in place to protect patients from errors, accidents, and injuries.

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Doctors order medications through a computer	100	5	69.80	100	2018 Leapfrog Hospital Survey	2018
Safe medication administration	100	5	68.26	100	2018 Leapfrog Hospital Survey	2018
Specially trained doctors care for ICU patients	100	5	49.17	100	2018 Leapfrog Hospital Survey	2018
Effective leadership to prevent errors	120.00	0.00	117.14	120.00	2018 Leapfrog Hospital Survey	2018
Staff work together to prevent errors	120.00	0.00	114.54	120.00	2018 Leapfrog Hospital Survey	2018
Track and reduce risks to patients	100.00	0.00	96.93	100.00	2018 Leapfrog Hospital Survey	2018
Enough qualified nurses	100.00	29.41	97.68	100.00	2018 Leapfrog Hospital Survey	2018
Handwashing	60.00	6.00	57.63	60.00	2018 Leapfrog Hospital Survey	2018
Communication with nurses	90	78	90.95	96	CMS	10/01/2016 - 09/30/2017
Communication with doctors	90	82	91.16	96	CMS	10/01/2016 - 09/30/2017
Responsiveness of hospital staff	82	63	84.20	94	CMS	10/01/2016 - 09/30/2017
Communication about medicines	76	61	77.96	89	CMS	10/01/2016 - 09/30/2017
Communication about discharge	87	69	86.88	96	CMS	10/01/2016 - 09/30/2017

EXHIBIT 14

Outcome Profile - Facility CareScience -- Sepsis Data

Report Limits:

Page by:
Risk Calc Mode: Standard

Month: OCTOBER 2017, NOVEMBER 2017, DECEMBER 2017, JANUARY 2018, FEBRUARY 2018, MARCH 2018, APRIL 2018, MAY 2018, JUNE 2018, JULY 2018, AUGUST 2018, SEPTEMBER 2018
Inpatient/Outpatient/Inpatient:

Outcomes DESC	Outcome Cases	Observed	Expected	Variation	O/E	SS
Mortality	566	17.14%	18.96%	-1.82%	0.90	***
Complications	587	26.92%	32.23%	-5.31%	0.84	***
30-Day Readmissions (PRA v2.1)	452	11.50%	16.80%	-5.30%	0.68	***
Hospital-Wide 30-Day Readmissions (PRA v4.0)	450	11.78%	17.06%	-5.28%	0.69	***
All-Cause 30-Day Readmissions - All	452	13.50%	20.87%	-7.37%	0.65	***
Inpatients	574	6.70	6.69	0.00	1.00	***
Geometric LOS	566	\$24,549	\$68,369	-\$43,820	0.36	***
Geometric Charge/case	566	\$22,467	\$15,873	\$6,594	1.42	***
Geometric Cost/case	574	10.17	8.34	1.83	1.22	***
Arithmetic LOS	566	\$37,130	\$88,615	-\$51,485	0.42	***
Arithmetic Charge/case	566	\$34,437	\$21,342	\$13,095	1.61	***
Arithmetic Cost/case						***

Disclosure: Data may not be finalized and all patients may not be included for (APR18, MAY18, JUN18, JUL18, AUG18, SEP18)

Confidential - Use Restricted by Agreement

Report Generated on 2/14/2019

EXHIBIT 15



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Neighborhood Socioeconomic Disadvantage and 30 Day Rehospitalizations: An Analysis of Medicare Data

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Author Contributions: Dr. Kind had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Kind, Jencks, Brock

Acquisition of data: Kind, Bartels, Smith

Analysis and interpretation of data: Kind, Jencks, Brock, Yu, Bartels, Ehlenbach, Greenberg, Smith

Drafting of the manuscript: Kind, Jencks, Brock

Critical revision of the manuscript for important intellectual content: Kind, Jencks, Brock, Yu, Bartels, Ehlenbach, Greenberg

Statistical analysis: Kind, Yu

Obtained funding: Kind, Bartels, Smith

Administrative, technical or material support: Kind, Bartels, Ehlenbach, Greenberg, Smith

Study supervision: Kind

Conflict of Interest Disclosure: No other disclosures are reported.

Previous Presentation: None

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Abstract

Background—Measures of socioeconomic disadvantage may enable improved targeting of programs to prevent rehospitalizations, but obtaining such information directly from patients can be difficult. Measures of US neighborhood socioeconomic disadvantage are more readily available, although rarely employed clinically.

Objective—To evaluate the association between neighborhood socioeconomic disadvantage at the census block-group level, as measured by Singh's validated Area Deprivation Index (ADI), and 30-day rehospitalization.

Design—Retrospective cohort study

Setting—United States

Patients—Random 5% national sample of fee-for-service Medicare patients discharged with congestive heart failure, pneumonia or myocardial infarction, 2004–2009 (N = 255,744)

Measurements—30-day rehospitalizations. Medicare data were linked to 2000 Census data to construct an ADI for each patient's census block-group, which were then sorted into percentiles by increasing ADI. Relationships between neighborhood ADI grouping and rehospitalization were evaluated using multivariate logistic regression models, controlling for patient sociodemographics, comorbidities/severity, and index hospital characteristics.

Results—The 30-day rehospitalization rate did not vary significantly across the least disadvantaged 85% of neighborhoods, which had an average rehospitalization rate=21%. However, within the most disadvantaged 15% of neighborhoods, rehospitalization rates rose from 22% to 27% with worsening ADI. This relationship persisted after full adjustment, with the most disadvantaged neighborhoods having a rehospitalization risk (adjusted risk ratio = 1.09, confidence interval 1.05–1.12) similar to that of chronic pulmonary disease (1.06, 1.04–1.08) and greater than that of diabetes (0.95, 0.94–0.97).

Limitations—No direct markers of care quality, access

Conclusions—Residence within a disadvantaged US neighborhood is a rehospitalization predictor of magnitude similar to chronic pulmonary disease. Measures of neighborhood disadvantage, like the ADI, could potentially be used to inform policy and post-hospital care.

Primary Funding Source—National Institute on Aging

INTRODUCTION

Thirty-day rehospitalizations affect 1 in 5 hospitalized Medicare patients, cost over \$17 billion annually, and result in hospital-based Medicare payment penalties for congestive

heart failure, pneumonia and acute myocardial infarction rehospitalizations (1). Most believe that all hospitals can prevent at least some rehospitalizations by using a spectrum of programs to better support vulnerable patients during the high-risk post hospital period (1–3). Yet, the targeting of these programs has proven challenging, potentially because important factors contributing to rehospitalizations are not well measured—like socioeconomic disadvantage (4, 5).

Socioeconomic disadvantage is a complex theoretical concept, which describes the state of being challenged by low income, limited education and substandard living conditions for both the individual and their neighborhood or social network (6, 7). Detailed assessment of an individual patient's socioeconomic status is a time-consuming and potentially uncomfortable task to add to a clinical encounter, and since such information is rarely available in the patient's medical record, clinical teams often overlook socioeconomic factors when creating individualized post-hospital care plans (8). Alternatively, measures of neighborhood socioeconomic disadvantage, such as concentration of poverty in the neighborhood surrounding the patient's residence, could be more easily accessed and assigned as a risk factor at the point of patient admission by using the patient's address. However, the association between neighborhood disadvantage and rehospitalization risk has not yet been established.

It is plausible that neighborhood socioeconomic disadvantage would influence rehospitalization risk, because vulnerable patients depend on neighborhood supports for stability generally (9–12), and these needs are likely to be increased in the period after hospital discharge (3). US safety-net hospitals, which serve socioeconomically disadvantaged areas, are more apt to be financially penalized for their rehospitalization rates (13–16). Living in a socioeconomically disadvantaged neighborhood has been associated with health behaviors (17), access to food (18, 19) and safety (20), and with outcomes such as mortality (10, 12–17), birth weight (21), and rehospitalization risk for heart failure (22). Additionally, important health indicators improve with moving people to areas of less concentrated poverty (23, 24).

In 2003, Singh created a composite measure of neighborhood socioeconomic disadvantage for the US -- the Area Deprivation Index (ADI) -- based on similar measures used in many other countries for resource planning and health policy development (25–29). The ADI is a factor-based index which uses 17 US Census poverty, education, housing and employment indicators to characterize census-based regions (25, 27–29), and has been correlated with a number of health outcomes including all-cause, cardiovascular, cancer and childhood mortality, and cervical cancer prevalence (25, 27–32). Socioeconomic disadvantage based on neighborhood risk through a Zip code-linked ADI does not require a potentially lengthy and intrusive discussion with patients and families, and could be easily made available to clinical teams and policymakers.

Our objective was to determine whether or not neighborhood socioeconomic disadvantage could be useful to clinical planning by examining its relevance in a population likely to be targeted by clinical improvement activities designed to reduce readmission risk. We analyzed the association between ADI, defined at the census block group level, and 30-day

rehospitalizations for patients discharged with congestive heart failure, pneumonia or acute myocardial infarction, the clinical conditions used for the current calculation of Medicare's rehospitalization penalties.

METHODS

Data Sources, Study Population

We used 2004–2009 data from the Chronic Condition Data Warehouse (33), including Medicare claims and enrollment files pre-linked to annual Medicare provider of service files for a 5% random national sample of Medicare beneficiaries. Beneficiaries who received railroad retirement benefits or were in a health maintenance organization were excluded because these groups have incomplete data. We identified 307,827 patients >65 years of age hospitalized with congestive heart failure, acute myocardial infarction or pneumonia using Medicare readmission measure definitions (34–36). We used the Zip+4 code listed for the patient's residence within Medicare data to link to the census block group with the same Zip +4 area in 2000 US Census data for the 50 US States and District of Columbia. Each census block group covers an area of 600–3,000 people, averaging 1,500 people (37). We excluded 52,083 patients without a Zip+4 code in their Medicare data ($n=9,741$) or whose documented Zip+4 code did not exist in the 2000 Census data ($n=42,342$). Patients in this latter category may include those who designate a post office box as their primary residence, or reside in post-year 2000 new Zip+4 areas, US Territories or institutions like prisons. Hand-checking of a small random sampling of these patients' Zip+4 codes suggests that most were assigned to a post office box. The final sample size was 255,744 patients. These patients originated from 4,802 unique hospitals (average 53.3 patients per hospital; range 1–743). The University of Wisconsin (UW) Institutional Review Board approved this study.

Variables

Census Block Group-Level Variables—We calculated ADI scores for each US Census block group using Singh's methodology (14, 16–18). This involved summing Singh's 17 Census indicators weighted by Singh's factor score coefficients for each indicator (25) (Table 1). See Appendix 1 for more detail on constructing the ADI. We examined the distribution of ADI values and sorted neighborhoods into percentiles by increasing ADI.

Patient-Level Variables—We constructed all-cause rehospitalization within 30 days of discharge from Medicare claims (34–36). Other variables drawn from Medicare files, included patient age, gender, race, Medicaid status, initial Medicare enrollment due to disability, index hospitalization length of stay and discharge to a skilled nursing facility. Race was categorized into 'White', 'Black', and 'Other' based upon the beneficiary race code. Each patient's Centers for Medicare and Medicaid Services hierarchical condition category (HCC) score, calculated from all outpatient and inpatient claims over the 12 months prior to the index hospitalization, was included as a risk adjustment measure (38). Comorbid conditions were identified using Elixhauser methods, incorporating data from the index hospitalization and from all hospitalizations and physician claims during the year prior to the index hospitalization (39). Of the comorbidities identified using this approach, 17 had frequencies of greater than 5% in the sample and were included as indicators. Comorbidities

occurring less often were compiled into an 'other comorbidity' indicator and included alcohol/drug abuse, rheumatoid arthritis/collagen vascular disease, chronic blood loss anemia, liver disease, lymphoma, metastatic cancer, solid tumor without metastases, paralysis, psychoses and peptic ulcer disease. We assessed rurality of each patient's zip code of residence using the US Department of Agriculture's Rural/Urban Commuting Area (RUCA) Codes, grouped into categories of "urban core areas," "suburban areas," "large town areas," and "small town/isolated rural areas" (40, 41). Index hospital characteristics, including Medicare geographic region, for-profit status and medical school affiliation, were drawn from the Medicare provider of services file corresponding to the patient's index hospitalization date (42). We estimated annual Medicare discharge volume for each hospital by multiplying the number of claims from each hospital in the 5% national sample, by 20. We then grouped hospitals into low, middle and high volume tertiles. About one percent of our sample was missing race data (n=291), and less than 3% were missing hospital medical school affiliation (n=777) and for-profit status (n=777). There were no missing data for other patient-level variables.

Statistical Analysis

We examined the unadjusted relationship between ADI percentile and 30-day rehospitalization, overall and by primary disease. Based upon the empiric ADI data, the most disadvantaged neighborhoods made up the top 15% of the distribution. To better assess for within-group differences, we divided this most disadvantaged 15% into three equally sized 5% groupings representing the third-most, the second-most and the most disadvantaged 5% of neighborhoods. The remainder of neighborhoods (85%) were grouped into a comparator category. We examined frequencies of patient and index hospital characteristics for each grouping.

We used logistic regression to assess the relationship between ADI grouping and 30-day rehospitalization. Next, to assess the full spectrum of ADI impact, we divided the distribution into 20 equally-sized neighborhood groupings of increasing ADI (5% each), and used logistic regression to assess the relationship between ADI grouping and rehospitalization. To investigate the within-hospital ADI effects (43), we employed conditional (44) and random effects logistic regression (45, 46). To assess for differences in disease grouping and rural-urban effects, the relationship was assessed using logistic regression models stratified by disease grouping and RUCA code. Patient numbers in stratified analyses were smaller, so we analyzed the most disadvantaged 15% of neighborhoods as a single group.

Control variables were drawn from theoretical models of rehospitalization (47) and included patient HCC score tertile, comorbidities, length of stay, discharge to skilled nursing facility, age, gender, race, Medicaid status, disability status and RUCA code of primary residence; and index hospital medical school affiliation, for-profit status and discharge volume tertile. We calculated adjusted risk ratios, predicted probabilities, and 95% confidence intervals from these models on the basis of marginal standardization, as per methods by Kleinman and Norton (48) and by Localio (49). All models were estimated twice—once accounting for hospital-level and patient-level clustering, and again using robust estimates of the variance.

Since no differences were noted, we present the more conservative robust estimates. All analyses were performed using SAS 9.3 (SAS Institute. SAS Statistical Software. 9.3 ed. Cary, NC: SAS Institute; 2011) and STATA 12 (StataCorp. *Stata Statistical Software*. 12.0 ed. College Station, TX: StataCorp LP; 2011).

Role of the Funding Sources

This project was supported by a National Institute on Aging Beeson Career Development Award, the UW School of Medicine and Public Health's Wisconsin Partnership Program and Health Innovation Program, and the UW NIH-Clinical and Translational Science Award. The UW Health Innovation Program provided assistance with Institutional Review Board application and data management. No other funding source had a role in the design or conduct; data collection, management, analysis or interpretation; or preparation, review or approval of the manuscript.

RESULTS

Neighborhood and Patient Characteristics by ADI Grouping

Patients in the most disadvantaged 15% of neighborhoods were more apt to be Black, on Medicaid, and to have higher rates of comorbidities, especially congestive heart failure, chronic pulmonary disease, and hypertension than patients from the other 85% of neighborhoods (Table 2). They were also more likely to have been hospitalized in a for-profit hospital. The majority of patients in the most disadvantaged 5% of neighborhoods lived in urban core areas. Those in the second- and third- most disadvantaged 5% groups were most likely to live in rural or large town areas.

30 Day Rehospitalization and Patient Neighborhood ADI

When compared to the other 85% of neighborhoods, residence within the most disadvantaged 15% of neighborhoods was associated with an increased risk of 30-day rehospitalization. The 30-day rehospitalization rate did not vary significantly across the least disadvantaged 85% of neighborhoods with an average rate of 21%. However, within the most disadvantaged 15% of neighborhoods, rehospitalization rates rose from 22% to 27% with worsening ADI (Figure 1). This pattern was maintained in all three primary diagnoses.

After adjustment, residence within the most disadvantaged 15% of neighborhoods continued to be associated with increased rehospitalization risk, with the most disadvantaged 5% having the greatest risk (Table 3; Appendix Tables 1 and 2). The adjusted rehospitalization risk ratios associated with residence within the most disadvantaged 15% of neighborhoods were similar to those of chronic pulmonary disease and peripheral vascular disease, and greater than those associated with having diabetes or being on Medicaid (Appendix Table 1). This association was noted across all primary diagnoses (Appendix Table 3). Sensitivity analyses, including conditional logistic regression models with control for hospital, also suggest that when comparing two patients, otherwise the same, who differ by reason of neighborhood deprivation index and arrive at the same hospital, the association of deprivation and readmission remains (Appendix Table 4).

Geographic Distribution

The prevalence of the most disadvantaged neighborhoods varied by Medicare geographic region (Table 4). Certain regions, like the Dallas, Atlanta, Chicago and Philadelphia regions, had a higher proportion of Medicare patients with the penalty-eligible conditions of congestive heart failure, pneumonia or acute myocardial infarction residing in the most disadvantaged US neighborhoods, than other regions. Some regions, like the Seattle region, had less than 5% of all eligible patients living in such neighborhoods. Figure 2 shows the locations of the most disadvantaged US patient neighborhoods (i.e., census block groups) in this study.

The distribution of the most disadvantaged neighborhoods also varied by rural-urban status. Nearly one-third of eligible patients residing in rural areas lived in neighborhoods that were among the most disadvantaged (Appendix Table 5). However, residence in the 15% most disadvantaged neighborhoods was a rehospitalization risk regardless of rural-urban area type.

DISCUSSION

Living in a severely disadvantaged neighborhood predicts rehospitalization as powerfully as does the presence of illnesses such as peripheral vascular disease or chronic pulmonary disease, and more powerfully than being on Medicaid or having diabetes. This effect holds after accounting for other patient- and hospital-level factors known to influence risk of rehospitalization, including race. Overall, patients from disadvantaged neighborhoods are at higher risk for rehospitalization regardless of their treating hospital.

Our findings suggest that neighborhood disadvantage is associated with a threshold effect, with strong and increasing risk of rehospitalization for residents of the most disadvantaged 15%. This threshold effect conforms with fundamental theories of social disadvantage (50) which indicate that there is generally some point beyond which individuals can no longer compensate and additional disadvantage leads to increasingly adverse outcomes (51). A wealth of social science research demonstrates that 'areas of concentrated poverty' (52, 53) place additional burdens on poor families that live within them, beyond the effect of the families' individual circumstances (54). It is clear that social support and a patient's environment can influence clinical outcomes, including rehospitalizations.

Although most clinicians would agree with our findings, in practice issues of socioeconomic disadvantage are often overlooked (8) for three reasons: 1) we do not agree on how to measure disadvantage, 2) we lack time and hesitate to ask for highly personal data, and 3) we do not always know what to do about disadvantage when we find it. These barriers have diminished recently. The ADI, which is widely studied and predicts rehospitalization, provides a useful measure that is usable right now, although better measures may be developed in the future. Because the ADI relies entirely on publicly-available census data, and (as of publication) will be available free on-line through the University of Wisconsin Health Innovation Program (www.HIPxChange.org) in the form of a Zip+4 code-ADI file as well as an individual look-up tool requiring only the patient's Zip+4 code to query, it avoids both the time burden and the intrusiveness of collecting sensitive data from the patient.

Based on patient address alone, clinicians and health systems could, at the point of first contact, use the ADI to screen for patients returning to the most challenging environments; supporting early targeting of more intensive transitional care services, prompting discussion of socioeconomic environment and need, and activating additional community resources for these patients. Transitional care interventions decrease rehospitalizations by employing a series of interactions designed to empower patients, monitor for early signs of disease worsening, and ensure medical plans and follow-up are in place. The targeting of transitional care programs can sometimes be challenging, especially in low-resource health settings. We offer the ADI as a potential way to refine such targeting. Placing a look-up table in a hospital's admission-processing system to supply this high-risk screener to the clinical team should be a very modest technical challenge.

Some European countries use composite measures of neighborhood socioeconomic disadvantage similar to the ADI to monitor population health and to allocate services and funding to ensure increased support in high-risk regions (25, 26). It could be used similarly in the US to refine characterizations of hospital service regions. Health systems and other health-related institutions could also use the ADI to identify neighborhoods that would most benefit from additional outreach and services. Policymakers could test innovative strategies for improving living conditions for older adults in severely disadvantaged areas (55). Finally, ADI scores could be used to direct funding towards community-based initiatives designed to lower unwanted rehospitalizations (56, 57).

Medicare hospital readmissions penalties fall more heavily on hospitals serving disadvantaged neighborhoods than on other hospitals (13–16). Adjusting for the socioeconomic status of individuals served (34–36) might level the playing field, but so far the debate has centered on the role of personal socioeconomic disadvantage in readmission risk, which remains unclear (4), and evidence that personal indicators of disadvantage are not ideally reliable or valid for elderly populations (58). Using the ADI to identify patients from the most severely disadvantaged neighborhoods could be explored as an adjuster for the current Medicare readmissions measures; one that might avoid the limitations of personal socioeconomic indicators and better screen for readmission risk.

A number of factors should be considered when interpreting these findings. To be included in our analyses a patient had to have a zip code of residence included within 2000 Census data. Therefore, the results of this analysis may not apply to patients without zip codes, such as the homeless, and those with zip codes absent in 2000 Census data. Although many of these latter patients list a post office box with Medicare, hospitals would have ample opportunity to gather residential Zip+4 codes directly. Census data collected in 2000 may not fully reflect neighborhood characteristics in the between-Census years of 2004–2009 used in this study. Next, patient-level analyses of any geographic-based measure, including the ADI, can introduce an ecological fallacy in which a region's aggregate traits are inappropriately attributed to a particular individual. However, our suggested use of the ADI as a clinical screener, which could trigger clinical teams to more fully assess for post-discharge need, should avoid this problem. Finally, the administrative data on which we relied does not contain direct markers of care quality or access that may affect rehospitalization risk. It is possible that hospitals that serve predominantly disadvantaged

neighborhoods provide different quality of care than hospitals that serve predominantly non-disadvantaged neighborhoods and this had an influence on our findings (43). The available data do not allow for a definitive conclusion in this regard but there is no clear evidence that safety-net hospitals, in general, differ from non-safety-net hospitals in their quality of care (59). Our analytic models provide evidence that the patients' neighborhood remains a strong predictor of rehospitalization regardless of other hospital-level factors. More robust data should be utilized to study these across-hospital effects in the future.

The effects associated with neighborhood disadvantage may result from person-level socioeconomic disadvantage for which community data are a proxy (10–12). In studies of child health and mental health outcomes, neighborhood disadvantage has been demonstrated to be an additional risk factor beyond personal disadvantage, with worse health and social outcomes for individuals who live in both poor families and poor neighborhoods than for individuals living in poor families in less poor neighborhoods (23, 60). Our main aim was to produce a meaningful estimate of disadvantage that could be easily used by clinicians and discharge planners. The relative importance of individual and community disadvantage cannot be determined from our data. Clarifying these associations deserves further study.

We chose the ADI for this analysis because it is a well-established US census-based measure which provides a composite view of socioeconomic disadvantage for all areas of the US and which can be used to reliably 'drill-down' to a relatively small geographic region (25). Others have explored using single income-related component measures as socioeconomic markers (5, 61, 62), but single construct approaches likely miss issues critical to post-hospital planning, such as education and living conditions. This may be why income alone shows mixed results as a rehospitalization predictor in studies to date (61, 62).

In conclusion, residence within a disadvantaged US neighborhood is a rehospitalization predictor of magnitude similar to important chronic diseases. Measures of neighborhood disadvantage, like the ADI, are easily created using data already routinely collected by the US government and freely available to the public, and may be useful in targeting patient- and community-based initiatives designed to lower unwanted rehospitalization.

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Appendix 1

CALCULATING THE SINGH AREA DEPRIVATION INDEX (ADI)

Introduction

In their analysis and monitoring of health, Great Britain, Sweden, Australia, New Zealand and many other nations use area-based composite deprivation indices; scores created by compiling measures of socioeconomic resources within a particular geographic area (25, 26). In 2003, Singh created a similar Area Deprivation Index (ADI) for the US (25, 27–29).

The ADI is a validated, factor-based deprivation index which uses 17 poverty, education, housing and employment indicators drawn from US Census data to create a measure of socioeconomic context for a particular census-based region (25, 27–29). The ADI has previously been used to document a number of socioeconomic-health associations, including the direct relationship between area deprivation and all-cause, cardiovascular, cancer and childhood mortality, and between area deprivation and cervical cancer prevalence (25, 27–32).

In the manuscript associated with this appendix, we calculated Area Deprivation Index (ADI) scores for each block group/neighborhood using methods proposed by Singh (25, 27–29) as a way to assess the socioeconomic context of a patient's neighborhood. This appendix provides interested readers with a more detailed account of how we calculated the ADI using Singh's methods.

Detailed Methods for Creating the ADI

Singh's ADI uses 17 US Census variables in its construction. We calculated these for each geographic unit, in this case a census-block group, using publically available 2000 US Census data. The US Census variables are as follows:

- Percent of population aged ≥ 25 years with < 9 years of education
- Percent of population aged ≥ 25 years with $<$ a high school diploma
- Percent of employed persons ≥ 16 years of age in white-collar occupations
- Median family income
- Income disparity (Defined by Singh as the log of $100 \times$ the ratio of the number of households with $< \$10,000$ in income to the number of households with $\geq \$50,000$ or more in income.) (25)
- Median home value

- Median gross rent
- Median monthly mortgage
- Percent owner-occupied housing units (home ownership rate)
- Percent of civilian labor force population \geq 16 years of age unemployed (unemployment rate)
- Percent of families below the poverty level
- Percent of population below 150% of the poverty threshold
- Percent of single-parent households with children < 18 years of age
- Percent of households without a motor vehicle
- Percent of households without a telephone
- Percent of occupied housing units without complete plumbing
- Percent of households with more than one person per room (crowding).

Using Singh's methods, these 17 indicators are weighted using factor score coefficients (see Table 1 of the accompanying manuscript). Using these Singh factors score coefficients, poverty, income and education have the largest relative weights amongst all of the 17 variables. These 17 US Census variables are multiplied by their factor weights and then summed for each geographic unit. The result is then transformed into a standardized index (the ADI) by arbitrarily setting the index mean at 100 and standard deviation at 20 (25). Using this approach, neighborhoods with higher ADI scores have higher levels of deprivation (25).

Typically, the ADI has been used to break geographic units into quintiles, deciles or other relatively ranked groupings by ADI score. To our knowledge, it has not been used as a predictor in its continuous, indexed form. For this study, we initially examined the distribution of ADI values and sorted neighborhoods into percentiles by increasing ADI.

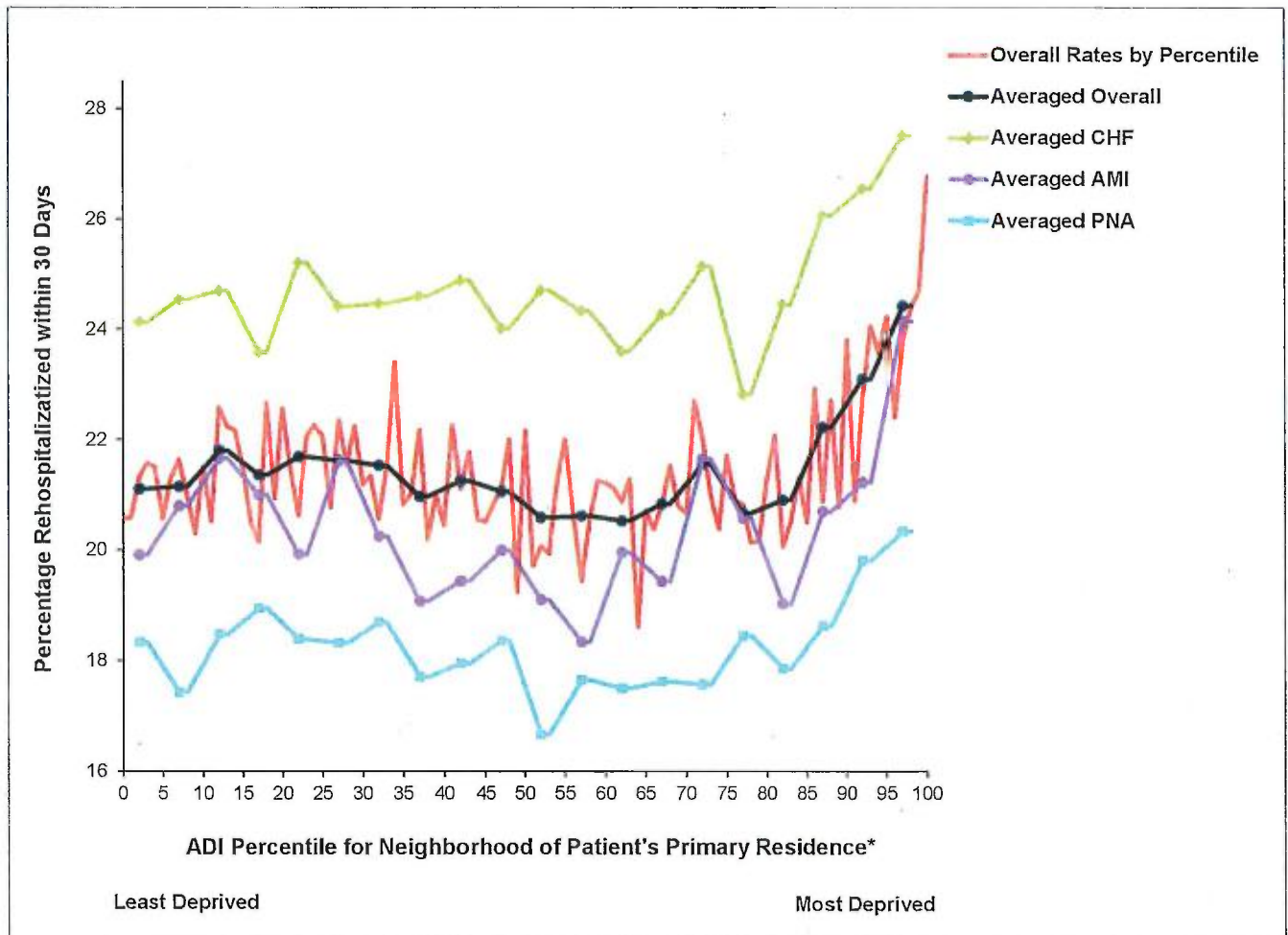


Figure 1. Unadjusted Relationship Between Area Deprivation Index (ADI) Percentile of a Medicare Patient's Neighborhood and 30 Day Rehospitalization

*On the ADI percentile range shown, 0 is the least socioeconomically disadvantaged group of neighborhoods ranging sequentially by equally sized neighborhood groupings up to 100 as the most disadvantaged group of neighborhoods. 'Average' lines represent the averaged relationship over each 5 ADI percentiles.

†Abbreviation: CHF = Congestive Heart Failure; AMI = Acute Myocardial Infarction; PNA = Pneumonia

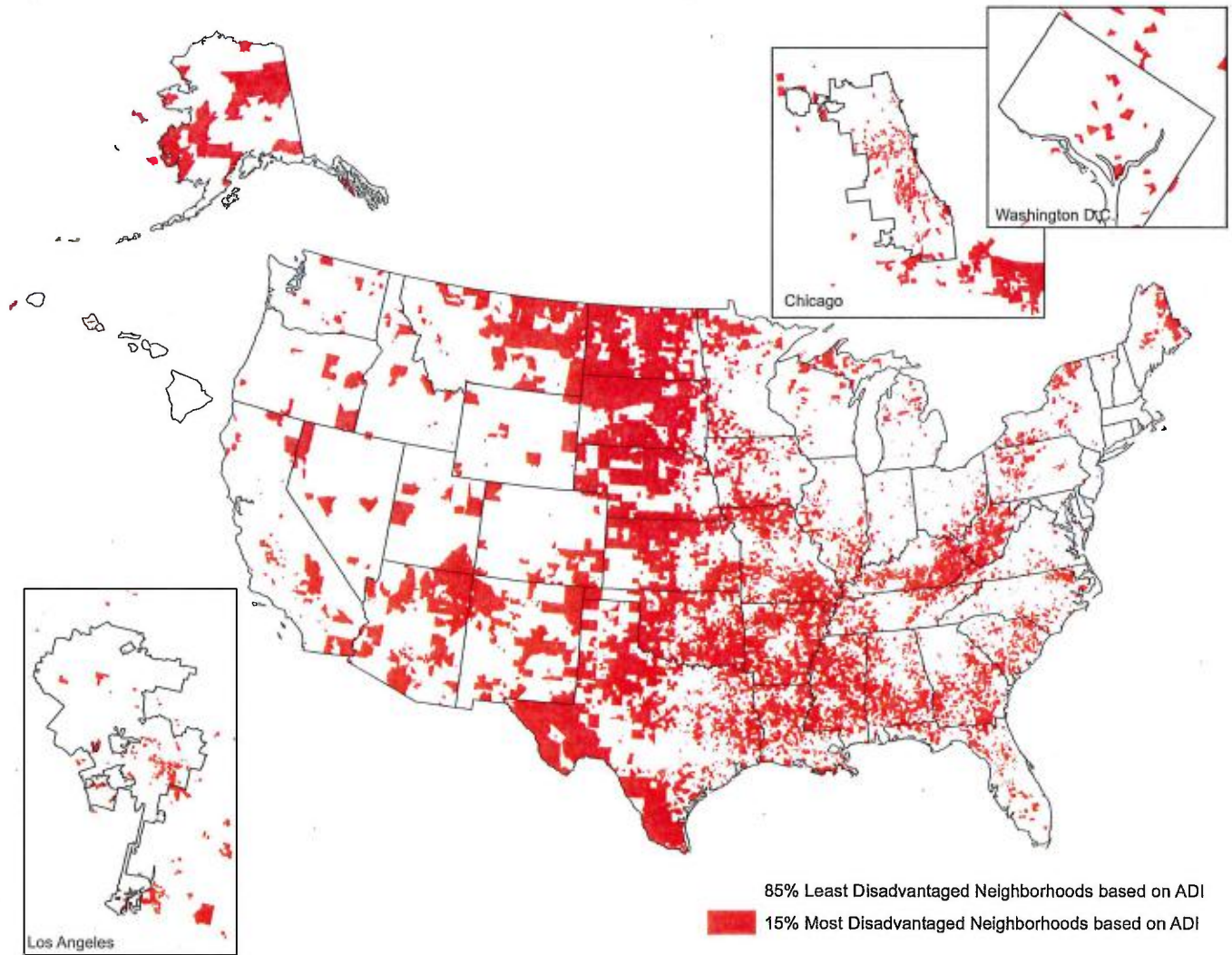


Figure 2. Locations of the 15% Most Disadvantaged Neighborhoods Based on Census Block Group Area Deprivation Index (ADI) Score

*Urban block groups/neighborhoods must be viewed at higher magnification within this figure, because they comprise smaller geographic areas than their rural counterparts.

Enlargements of sample urban areas are offered to demonstrate.

Table 1

Census Data Block Group Components and Factor Score Coefficients in Singh's Area Deprivation Index (ADI)*

Census Block Group Components	Factor Score Coefficients
Percent of the block group's population aged ≥ 25 years with < 9 years of education	0.0849
Percent aged ≥ 25 years with greater than or equal to a high school diploma	-0.0970
Percent of employed persons ≥ 16 years of age in white-collar occupations	-0.0874
Median family income	-0.0977
Income disparity [†]	0.0936
Median home value	-0.0688
Median gross rent	-0.0781
Median monthly mortgage	-0.0770
Percent owner-occupied housing units (home ownership rate)	-0.0615
Percent of civilian labor force population ≥ 16 years of age unemployed (unemployment rate)	0.0806
Percent of families below the poverty level	0.0977
Percent of population below 150% of the poverty threshold	0.1037
Percent of single-parent households with children < 18 years of age	0.0719
Percent of occupied housing units without a motor vehicle	0.0694
Percent of occupied housing units without a telephone	0.0877
Percent of occupied housing units without complete plumbing (log)	0.0510
Percent of occupied housing units with more than one person per room (crowding)	0.0556

* Components and factor score coefficients drawn from reference 28. All coefficients are multiplied by -1 to ease interpretation (higher ADI = higher disadvantage).

[†] Income disparity defined by Singh as the log of 100*ratio of number of households with $< \$10,000$ income to number of households with $\$50,000+$ income.

Key Characteristics of Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia, Overall and by Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence, 2004–2009 (N=255,744)*

Table 2

Key Characteristics	Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence				
	Overall (N=255,744)	Least Disadvantaged 85% (N=12,813)	Third-Most Disadvantaged 5% (N=12,798)	Second-Most Disadvantaged 5% (N=12,779)	Most Disadvantaged 5% (N=12,772)
	%	%	%	%	%
<i>Patient Characteristics</i>					
Average Age in Years (SD)	80.6 (8)	80.8 (8)	79.7 (8)	79.3 (8)	79.2 (8)
65–69 years	10	10	13	13	14
70–74 years	15	14	17	18	18
75–79 years	19	19	20	21	20
80–84 years	22	23	21	21	21
≥85 years	34	34	30	28	28
Gender:					
Male	39	39	37	37	36
Female	61	61	63	63	64
Race:					
White	87	90	82	76	58
Black	9	7	15	20	33
Other	4	4	3	4	9
Medicaid:					
No	78	81	67	64	53
Yes	22	19	33	36	47
Disabled:					
No	98	98	98	97	97
Yes	2	2	2	3	3
Rural Urban Commuting Area Code for Patient Residence:					
Urban Core Area	66	69	42	45	64
Suburban Area	8	9	6	4	2

Key Characteristics	Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence					
	Overall (N=255,744)	Least Disadvantaged 85% (N=12,813)	Third-Most Disadvantaged 5% (N=12,798)	Second-Most Disadvantaged 5% (N=12,779)	Most Disadvantaged 5% (N=12,772)	
	%	%	%	%	%	%
Large Town Area	14	12	21	21	18	
Small Town and Isolated Rural Area	12	9.3	31	30	17	
Average HCC Score Prior to Index Hospitalization Date (SD)	2.89 (1.85)	2.87 (1.85)	2.86 (1.77)	2.95 (1.84)	3.13 (1.97)	
Comorbidities:						
Hypertension	57	56	59	61	62	
Congestive Heart Failure	48	47	51	53	54	
Fluid and Electrolyte Disorders	39	38	40	42	43	
Chronic Pulmonary Disease	38	37	30	43	42	
Deficiency Anemias	29	29	30	32	35	
Valvular Disease	22	23	20	20	21	
Renal Failure	21	20	21	24	25	
Diabetes, Uncomplicated	17	17	19	19	20	
Hypothyroidism	16	17	17	16	14	
Peripheral Vascular Disease	16	16	17	19	19	
Depression	12	12	14	13	12	
Other Neurological Disorders	12	12	12	14	12	
Diabetes, Complicated	11	11	12	15	15	
Pulmonary Circulation Disease	9	9	9	10	10	
Obesity	7	7	8	9	9	
Coagulopathy	6	6	6	6	7	
Weight Loss	6	6	6	8	8	
Other Comorbidity	26	26	26	26	27	
Primary Diagnosis of Index Hospitalization:						
Congestive Heart Failure	44	43	44	46	49	
Acute Myocardial Infarction	17	18	16	15	15	

Key Characteristics	Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence					
	Overall (N=255,744)	Least Disadvantaged (N=12,813)	Third-Most Disadvantaged (N=12,798)	Second-Most Disadvantaged (N=12,779)	Most Disadvantaged (N=12,772)	
	%	%	%	%	%	
Pneumonia	39	39	40	39	36	
Average Length of Stay of Index Hospitalization in Days (SD)	5.6 (4.8)	5.6 (4.8)	5.5 (4.6)	5.5 (4.4)	5.8 (5.5)	
2 Or Fewer Days	18	19	18	17	17	
3-4 Days	33	33	34	35	32	
5-6 Days	21	21	21	21	21	
7 Or More Days	28	28	27	27	30	
Discharged to a Skilled Nursing Facility:						
No	77	76	78	78	80	
Yes	23	24	22	22	20	
<i>Index Hospital Characteristics</i>						
Medical School Affiliation:						
None	58	58	66	63	50	
Minor	22	22	21	21	23	
Major	20	20	14	16	27	
Hospital Type:						
Non-Profit/Public	87	88	84	83	83	
For Profit	13	12	16	17	17	
Average Annual Total Discharge Volume (SD)	6920 (5423)	7053 (5406)	5677 (4967)	5839 (5155)	6984 (6092)	
Highest Tertile (12,576 Average Annual Discharges)	35	36	27	28	33	
Middle Tertile (5,541 Average Annual Discharges)	34	35	30	30	32	
Lowest Tertile (1,950 Average Annual Discharges)	30	29	43	42	35	
<i>30 Day Patient Outcomes</i>						
Rehospitalization	21	21	22	23	24	
Death	16	16	15	15	13	

* Values represent percentages unless otherwise specified

Abbreviation: SD= Standard Deviation; HCC=Hierarchical Condition Category Score created through the Centers for Medicare and Medicaid Services

Table 3

Risk of Rehospitalization Within 30 Days for Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia by Area Deprivation Index (ADI) Ranking of the Patient's Neighborhood of Residence, 2004–2009 (N=255,744)*

Characteristic	Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Predicted [‡] Probability (95% CI)
<i>Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence</i>					
Least Disadvantaged 85% (Baseline Group), ADI Range = -52.63–113.44	1.00	REF	1.00	REF	0.21 (0.21, 0.21)
Third-Most Disadvantaged 5%, ADI Range = 113.45–115.12	1.05 (1.02, 1.09)	0.003	1.05 (1.01, 1.08)	0.01	0.22 (0.22, 0.23)
Second-Most Disadvantaged 5%, ADI Range = 115.13–117.46	1.09 (1.06, 1.13)	<0.001	1.07 (1.03, 1.1)	<0.001	0.23 (0.22, 0.23)
Most Disadvantaged 5%, ADI Range = 117.47–129.10	1.16 (1.12, 1.19)	<0.001	1.09 (1.05, 1.12)	<0.001	0.23 (0.22, 0.24)

* All models employ multivariate logistic regression methods to assess the relationship between ADI grouping and 30- day rehospitalization to produce risk ratios (using the methods of Kleinman and Norton (48)) and predicted probabilities.

[†] All models adjusted for: Hierarchical Condition Category Score; indicator variables denoting the presence of comorbidities including hypertension, fluid and electrolyte disorders, congestive heart failure, chronic pulmonary disease, deficiency anemias, uncomplicated diabetes, complicated diabetes, valvular disease, hypothyroidism, peripheral vascular disease, coagulopathy, depression, other neurological disorders, obesity, pulmonary circulation disease, renal failure, weight loss and other comorbidity; length of stay of the index hospitalization; and an indicator variable for whether a patient was discharged to a skilled nursing facility; patient demographics including age, gender and race (White, Black or other), Medicaid status, disability status, Rural Urban Commuting Area (RUCA) for patient residence and index hospital characteristics including medical school affiliation, for-profit status and total discharge volume tertile. Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

Table 4

Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia, 2004–2009, and Residing in the 15% Most Disadvantaged Neighborhoods, by Medicare Region of Index Hospital (N=255,744)

Centers for Medicare and Medicaid Services Region	Number of Eligible Congestive Heart Failure, Acute Myocardial Infarction and Pneumonia Medicare Patients	Eligible Patients Residing in the 15% Most Disadvantaged Neighborhoods by ADI % (N)
Boston Region (I)	15566	4 (584)
New York Region (II)	26362	10 (2744)
Philadelphia Region (III)	26557	13 (3530)
Atlanta Region (IV)	54867	18 (9846)
Chicago Region (V)	54748	11 (6273)
Dallas Region (VI)	28559	35 (9904)
Kansas City Region (VII)	15395	23 (3486)
Denver Region (VIII)	5676	13 (754)
San Francisco Region (IX)	20937	5 (943)
Seattle Region (X)	6301	3 (212)

Appendix Table 1

Risk of Rehospitalization Within 30 Days for Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia by Area Deprivation Index (ADI) Ranking of the Patient's Neighborhood of Residence, 2004–2009 (N=255,744)*†

Characteristic	Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Predicted [†] Probability (95% CI)
<i>Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence</i>					
Least Disadvantaged 85% (Baseline Group), ADI Range = -52.63–113.44	1.00	REF	1.00	REF	0.21 (0.21, 0.21)
Third-Most Disadvantaged 5%, ADI Range = 113.45–115.12	1.05 (1.02, 1.09)	0.003	1.05 (1.01, 1.08)	0.01	0.22 (0.22, 0.23)
Second-Most Disadvantaged 5%, ADI Range = 115.13–117.46	1.09 (1.06, 1.13)	<0.001	1.07 (1.03, 1.1)	<0.001	0.23 (0.22, 0.23)
Most Disadvantaged 5%, ADI Range = 117.47–129.10	1.16 (1.12, 1.19)	<0.001	1.09 (1.05, 1.12)	<0.001	0.23 (0.22, 0.24)
<i>Patient Comorbidity/Severity</i>					
HCC Score Prior to Index Hospitalization Date			1.12 (1.11, 1.13)	<0.001	
<i>Comorbidities:</i>					
Hypertension			0.92 (0.9, 0.93)	<0.001	
Fluid and Electrolyte Disorders			1.08 (1.06, 1.1)	<0.001	
Congestive Heart Failure			1.16 (1.14, 1.18)	<0.001	
Chronic Pulmonary Disease			1.06 (1.04, 1.08)	<0.001	
Deficiency Anemias			1.09 (1.07, 1.11)	<0.001	
Diabetes, Uncomplicated			0.95 (0.94, 0.97)	<0.001	
Diabetes, Complicated			1.03 (1, 1.05)	0.02	
Valvular Disease			1.08 (1.06, 1.1)	<0.001	
Hypothyroidism			1.03 (1.01, 1.05)	0.01	
Peripheral Vascular Disease			1.07 (1.05, 1.09)	<0.001	
Coagulopathy			1 (0.97, 1.03)	0.85	
Depression			1.05 (1.02, 1.07)	<0.001	
Other Neurological Disorders			0.98 (0.96, 1)	0.09	
Obesity			1.02 (0.99, 1.05)	0.22	
Pulmonary Circulation Disease			1.05 (1.02, 1.07)	<0.001	

Characteristic	Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Predicted [†] Probability (95% CI)
Renal Failure			1.11 (1.09, 1.14)	<0.001	
Weight Loss			0.96 (0.93, 0.99)	0.01	
Other Comorbidity			1.03 (1.01, 1.05)	<0.001	
Length of Stay of Index Hospitalization:					
2 Or Fewer Days			Ref		
3–4 Days			1.07 (1.04, 1.09)	<0.001	
5–6 Days			1.16 (1.13, 1.19)	<0.001	
7 Or More Days			1.34 (1.31, 1.37)	<0.001	
Discharged to a Skilled Nursing Facility:					
No			Ref		
Yes			1.13 (1.11, 1.15)	<0.001	
<i>Patient Demographics</i>					
Age:					
65–69 years			Ref		
70–74 years			1.01 (0.98, 1.05)	0.38	
75–79 years			1.01 (0.98, 1.04)	0.50	
80–84 years			1.01 (0.98, 1.05)	0.36	
≥85 years			0.99 (0.96, 1.02)	0.42	
Gender:					
Male			Ref		
Female			0.99 (0.97, 1)	0.11	
Race:					
White			Ref		
Black			1.06 (1.04, 1.09)	<0.001	
Other			1 (0.96, 1.04)	0.99	
Medicaid:					
No			Ref		
Yes			1 (0.98, 1.02)	0.82	
Disability:					
No			Ref		

Characteristic	Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Predicted [‡] Probability (95% CI)
Yes			1.06 (1, 1.12)	0.03	
Rural Urban Commuting Area (RUCA) for Patient Residence:					
Urban Core Area			Ref		
Suburban Area			1 (0.97, 1.03)	0.91	
Large Town Area			0.96 (0.94, 0.99)	0.00	
Small Town and Isolated Rural Area			1 (0.97, 1.03)	0.97	
<i>Index Hospital Characteristics</i>					
Medical School Affiliation:					
None			Ref		
Minor			1 (0.98, 1.02)	0.73	
Major			1.02 (1, 1.05)	0.02	
Hospital Type:					
Non-Profit/Public			Ref		
For Profit			1.01 (0.99, 1.03)	0.34	
Average Annual Total Discharge Volume:					
Highest Tertile (12,576 Average Annual Discharges)			Ref		
Middle Tertile (5,541 Average Annual Discharges)			0.99 (0.97, 1.01)	0.16	
Lowest Tertile (1,950 Average Annual Discharges)			0.97 (0.95, 0.99)	0.00	

* All models employ multivariate logistic regression methods to assess the relationship between ADI grouping and 30- day rehospitalization to produce risk ratios (using the methods of Kleinman and Norton (48)) and predicted probabilities.

[†] Adjusted for all variables listed.

[‡] Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

Appendix Table 2

Risk of Rehospitalization Within 30 Days for Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia by Area Deprivation Index (ADI) Ranking of the Patient's Neighborhood of Residence, 2004–2009 (N=255,744) *

Characteristic	Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Predicted [†] Probability (95% CI)
Area Deprivation Index (ADI) 5% of the Patient's Neighborhood of Residence					
Group 1, ADI Range = -52.63--69.49 (Least Disadvantaged 5%)	1.00	REF	1.00	REF	0.21 (0.21, 0.22)
Group 2, ADI Range = 69.50--81.36	1 (0.95, 1.05)	0.93	0.99 (0.94, 1.03)	0.59	0.21 (0.2, 0.22)
Group 3, ADI Range = 81.37--87.69	1.03 (0.98, 1.08)	0.18	1.02 (0.97, 1.06)	0.52	0.22 (0.21, 0.22)
Group 4, ADI Range = 87.00--91.75	1.01 (0.96, 1.06)	0.63	1 (0.95, 1.04)	0.91	0.21 (0.2, 0.22)
Group 5, ADI Range = 91.76--94.81	1.03 (0.98, 1.08)	0.26	1.02 (0.97, 1.06)	0.48	0.22 (0.21, 0.22)
Group 6, ADI Range = 94.82--97.16	1.02 (0.98, 1.07)	0.32	1.01 (0.97, 1.06)	0.59	0.22 (0.21, 0.22)
Group 7, ADI Range = 97.17--99.31	1.02 (0.97, 1.07)	0.42	1.02 (0.97, 1.07)	0.44	0.22 (0.21, 0.22)
Group 8, ADI Range = 99.32--101.18	0.99 (0.95, 1.04)	0.78	1 (0.95, 1.05)	0.96	0.21 (0.21, 0.22)
Group 9, ADI Range = 101.19--102.91	1.01 (0.96, 1.05)	0.79	1.01 (0.96, 1.06)	0.70	0.21 (0.21, 0.22)
Group 10, ADI Range = 102.92--104.46	1 (0.95, 1.05)	0.93	1.01 (0.96, 1.05)	0.80	0.21 (0.21, 0.22)
Group 11, ADI Range = 104.47--105.86	0.98 (0.93, 1.02)	0.31	0.98 (0.94, 1.03)	0.51	0.21 (0.2, 0.22)
Group 12, ADI Range = 105.87--107.15	0.98 (0.93, 1.02)	0.34	0.98 (0.93, 1.03)	0.37	0.21 (0.2, 0.22)
Group 13, ADI Range = 107.16--108.36	0.97 (0.93, 1.02)	0.25	0.98 (0.93, 1.02)	0.31	0.21 (0.2, 0.21)
Group 14, ADI Range = 108.37--109.55	0.99 (0.94, 1.03)	0.60	0.99 (0.94, 1.04)	0.68	0.21 (0.2, 0.22)
Group 15, ADI Range = 109.56--110.75	1.02 (0.97, 1.07)	0.38	1.02 (0.97, 1.07)	0.46	0.22 (0.21, 0.22)
Group 16, ADI Range = 110.76--112.02	0.98 (0.93, 1.03)	0.39	0.99 (0.94, 1.04)	0.61	0.21 (0.2, 0.22)
Group 17, ADI Range = 112.03--113.44	0.99 (0.94, 1.04)	0.69	0.99 (0.94, 1.04)	0.74	0.21 (0.2, 0.22)
Group 18, ADI Range = 113.45--115.12 (Third-Most Disadvantaged 5%)	1.05 (1, 1.1)	0.03	1.05 (1, 1.1)	0.06	0.22 (0.22, 0.23)
Group 19, ADI Range = 115.13--117.46 (Second-Most Disadvantaged 5%)	1.09 (1.04, 1.14)	<0.001	1.06 (1.01, 1.11)	0.01	0.23 (0.22, 0.23)
Group 20, ADI Range = 117.47--129.10 (Most Disadvantaged 5%)	1.16 (1.1, 1.21)	<0.001	1.08 (1.03, 1.13)	0.001	0.23 (0.22, 0.24)

* All models employ multivariate logistic regression methods to assess the relationship between ADI grouping and 30-day rehospitalization to produce risk ratios (using the methods of Kleinman and Norton (48)) and predicted probabilities.

[†] All models adjusted for: Hierarchical Condition Category Score; indicator variables denoting the presence of comorbidities including hypertension, fluid and electrolyte disorders, congestive heart failure, chronic pulmonary disease, deficiency anemias, uncomplicated diabetes, complicated diabetes, valvular disease, hypothyroidism, peripheral vascular disease, coagulopathy, depression, other neurological disorders, obesity, pulmonary circulation disease, renal failure, weight loss and other comorbidity; length of stay of the index hospitalization; and an indicator variable for whether a patient was discharged to a skilled nursing facility; patient demographics including age, gender and race (White, Black or other), Medicaid status, disability status, Rural Urban Commuting Area (RUCA) for patient residence and index hospital characteristics including medical school affiliation, for-profit status and total discharge volume tertile. Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

Appendix Table 3

Risk of Rehospitalization Within 30 Days for Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia, 2004–2009, by Area Deprivation Index (ADI) Ranking of the Patient's Neighborhood of Residence and Primary Discharge Diagnosis (N=255,744)*

Characteristic	Congestive Heart Failure (N=112,192)		Acute Myocardial Infarction (N=44,582)		Pneumonia (N=98,970)	
	Adjusted [†] Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value	Adjusted [†] Risk Ratio (95% CI)	P-Value
<i>Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence</i>						
Least Disadvantaged 85% (Baseline Group), ADI Range = -52.63–113.44	1.00	REF	1.00	REF	1.00	REF
Third-Most Disadvantaged 5%, ADI Range = 113.45–115.12	1.06 (1.02, 1.11)	0.008	1.02 (0.94, 1.11)	0.595	1.03 (0.97, 1.09)	0.310
Second-Most Disadvantaged 5%, ADI Range = 115.13–117.46	1.06 (1.01, 1.11)	0.011	1.03 (0.94, 1.12)	0.569	1.09 (1.02, 1.15)	0.006
Most Disadvantaged 5%, ADI Range = 117.47–129.10	1.08 (1.03, 1.13)	0.001	1.09 (1, 1.19)	0.046	1.08 (1.01, 1.14)	0.020

* All models employ multivariate logistic regression methods to assess the relationship between ADI grouping and 30-day rehospitalization to produce adjusted risk ratios for each diagnosis by using the methods of Kleinman and Norton (48).

[†] All models adjusted for: Hierarchical Condition Category Score; indicator variables denoting the presence of comorbidities including hypertension, fluid and electrolyte disorders, congestive heart failure, chronic pulmonary disease, deficiency anemias, uncomplicated diabetes, complicated diabetes, valvular disease, hypothyroidism, peripheral vascular disease, coagulopathy, depression, other neurological disorders, obesity, pulmonary circulation disease, renal failure, weight loss and other comorbidity; length of stay of the index hospitalization; and an indicator variable for whether a patient was discharged to a skilled nursing facility; patient demographics including age, gender and race (White, Black or other), Medicaid status, disability status, Rural Urban Commuting Area (RUCA) for patient residence and index hospital characteristics including medical school affiliation, for-profit status and total discharge volume tertile. Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

Appendix Table 4

Unadjusted and Adjusted Results from Conditional Logistic Regression (N=252,155)[†]

Characteristic	Unadjusted Odds Ratio (95% CI)	P-Value	Adjusted* Odds Ratio (95% CI)	P-Value
<i>Area Deprivation Index (ADI) Grouping of the Patient's Neighborhood of Residence</i>				
Least Disadvantaged 85% (Baseline Group), ADI Range = -52.63--113.44	1.00	REF	1.00	REF
Third-Most Disadvantaged 5%, ADI Range = 113.45--115.12	1.06 (1.01, 1.11)	0.011	1.04 (0.99, 1.09)	0.131
Second-Most Disadvantaged 5%, ADI Range = 115.13--117.46	1.14 (1.08, 1.19)	<0.001	1.09 (1.04, 1.14)	0.001
Most Disadvantaged 5%, ADI Range = 117.47--129.10	1.14 (1.09, 1.19)	<0.001	1.08 (1.03, 1.14)	0.001

* All models adjusted for: Hierarchical Condition Category Score; indicator variables denoting the presence of comorbidities including hypertension, fluid and electrolyte disorders, congestive heart failure, chronic pulmonary disease, deficiency anemias, uncomplicated diabetes, complicated diabetes, valvular disease, hypothyroidism, peripheral vascular disease, coagulopathy, depression, other neurological disorders, obesity, pulmonary circulation disease, renal failure, weight loss and other comorbidity; length of stay of the index hospitalization; and an indicator variable for whether a patient was discharged to a skilled nursing facility; patient demographics including age, gender and race (White, Black or other), Medicaid status, disability status, Rural Urban Commuting Area (RUCA) for patient residence and index hospital characteristics including medical school affiliation, for-profit status and total discharge volume tertile. Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

[†] 2523 patients (642 hospitals) dropped from analysis because of all positive or all negative outcomes within group.

Appendix Table 5

Medicare Patients Discharged with Primary Diagnoses of Congestive Heart Failure, Acute Myocardial Infarction, and Pneumonia, 2004–2009, and Residing in the 15% Most Disadvantaged Neighborhoods, by Rural Urban Commuting Area (RUCA) Code of Patient Residence (N=255,744)[†]

Rural Urban Commuting Area (RUCA) of Patient Residence	Number of Eligible Congestive Heart Failure, Acute Myocardial Infarction and Pneumonia Medicare Patients	Eligible Patients Residing in the 15% Most Disadvantaged Neighborhoods by ADI % (N)	Risk of Rehospitalization within 30 Days for Patients Residing in the 15% Most Disadvantaged Neighborhoods Stratified by RUCA Code *		
			Unadjusted Risk Ratio (95% CI)	P-Value	Adjusted [‡] Risk Ratio (95% CI)
Urban Core Area	195323	12 (23895)	1.11 (1.08, 1.13)	<0.001	1.05 (1.03, 1.08)
Sub-Urban Area	6839	8 (534)	1.17 (0.99, 1.35)	0.052	1.1 (0.92, 1.28)
Large Town Area	33723	23 (7770)	1.11 (1.06, 1.17)	<0.001	1.06 (1.01, 1.11)
Small Town and Isolated Rural Area	19042	32 (6071)	1.16 (1.1, 1.23)	<0.001	1.14 (1.07, 1.21)

* As compared to eligible patients not residing in the 15% most disadvantaged neighborhoods

[†] All models employ multivariate logistic regression methods to assess the relationship between ADI grouping and 30-day rehospitalization to produce adjusted risk ratios for each diagnosis by using the methods of Kleinman and Norton (48).

[‡] All models adjusted for: Hierarchical Condition Category Score; indicator variables denoting the presence of comorbidities including hypertension, fluid and electrolyte disorders, congestive heart failure, chronic pulmonary disease, deficiency anemias, uncomplicated diabetes, complicated diabetes, valvular disease, hypothyroidism, peripheral vascular disease, coagulopathy, depression, other neurological disorders, obesity, pulmonary circulation disease, renal failure, weight loss and other comorbidity; length of stay of the index hospitalization; and an indicator variable for whether a patient was discharged to a skilled nursing facility; patient demographics including age, gender and race (White, Black or other), Medicaid status, disability status, and index hospital characteristics including medical school affiliation, for-profit status and total discharge volume tertile. Race data were missing for 291 patients. Index hospital medical school affiliation and for-profit status were missing for 777 patients.

